Patient Reactivation Form

If you have previously been treated by Comber Physical Therapy & Fusion Chiropractic, please complete the following form so that we may keep your file up to date.

In which location were you most recently seen? New Town Lightfoot

Please tell us your new diagnosis/complaint & your referring physician.

_____

Has your address or telephone number changed? No Yes

If yes, new info: _____

Has your insurance information changed in ANY way (new insurance company, different policy, new policy holder, etc)? No Yes

If yes, new info: _____

Please make sure we take a copy of your new/updated insurance cards.

Would you like to update or change your emergency contact information? No Yes

If yes, new info: _____

Have you received physical, occupation, or speech therapy from another facility OR via home health care within the past year? If so, please indicate which type, where, and approximate dates:

_____

_____

MISSED APPOINTMENT POLICY: If a patient schedules an appointment and fails to show up or cancels the appointment less than 24 hours in advance, they will be issued a **$25 no-show fee.** Another copy of our detailed missed appointment policy is available upon request.

_____ _____

Signature of Patient or Legal Guardian Printed name of Patient

_____

Date

COMBER PHYSICAL THERAPY
FUSION CHIROPRACTIC

Mooretown Road Office
109-B Bulifants Blvd., Williamsburg, VA 23188
P (757) 229-9740 F (757) 229-9741

New Town Office
5388 Discovery Park Blvd., Ste 100, Williamsburg, VA 23188
P (757) 903-4230 F (757) 903-4231

MEDICAL SCREENING FORM

Date _____

Name _____

Age _____ **/ DOB** _____

Referring Physician _____

What is your chief complaint today?

_____

Have you or any immediate family member ever been told you have:

	SELF	FAMILY
Diabetes	Yes / No	Yes / No
High Blood Pressure	Yes / No	Yes / No
Heart Disease	Yes / No	Yes / No
Angina/Chest Pain	Yes / No	Yes / No
Stroke	Yes / No	Yes / No
Osteoporosis	Yes / No	Yes / No
Rheumatoid arthritis	Yes / No	Yes / No
Cancer	Yes / No	Yes / No

Have you experienced any of the following in the past three months:

Nausea/Vomiting	Yes / No
Fever/Sweats/Chills	Yes / No
Unexplained Weight Change	Yes / No
Numbness or Tingling	Yes / No
Changes in Appetite	Yes / No
Difficulty Swallowing	Yes / No
Changes in Bowel or Bladder Function	Yes / No
Shortness of Breath	Yes / No
Dizziness	Yes / No
Upper Respiratory Infection	Yes / No
Urinary Tract Infection	Yes / No
A Change in Your Health	Yes / No

Date of last physical exam _____

Medications currently being taken _____

_____

_____

_____

_____

_____

_____

Surgeries	**Dates**
_____	_____
_____	_____
_____	_____
_____	_____

Is your need for physical therapy the result of an injury?
YES or **NO**

IfYES, date of injury was _____
IfYES, injury was from WORK/AUTO/OTHER
If OTHER, please explain _____

Do you have a history of:

Headaches	Yes / No
Bronchitis	Yes / No
Kidney Disease	Yes / No
Rheumatic Fever	Yes / No
Ulcers	Yes / No
Sexually Transmitted Disease	Yes / No
Incontinence (urinary or fecal)	Yes / No
Seizures	Yes / No
Allergies/Asthma	Yes / No
Autoimmune Disease	Yes / No

Are you currently:

Depressed	Yes / No
Under Stress	Yes / No
Pregnant	Yes / No

Please circle the following:

Are your symptoms
getting worse/the same/improving

How do you sleep at night
fine/moderate difficulty/only with medication

Do you have problems with (circle all that apply)
Hearing/vision/speech/communication

Do you drink alcoholic beverages
YES or NO
If YES, how many drink per week? _____

Do you or have you in the past used tobacco
YES or NO
If YES, _____ per day for _____ years
Last tobacco use _____

Please use the diagram below to indicate where you feel symptoms right now.
Use the following key to indicate the different types of symptoms:

KEY

Pins and Needles = 00000	Stabbing = //////
Deep Ache = ZZZZZ	Burning = XXXXX