Kiwi PT
Orthopedic Rehabilitation

Patient Name:_____ Today's Date: _____

How did you hear about us? □ Physician's Office □ Friend/Neighbor □ Website/Facebook

□ Other _____

1. Is this injury related to: □ Work □ Car Accident □ Other Potential Liability/Potential Lawsuit □ NA
2. Do you have a Primary Care Physician/Family Doctor? □ YES □ NO
   If yes, have you had an appointment with him/her in the last 1 month? □ YES □ NO
3. Race/Ethnicity:
   □ African American □ Native American □ Caucasian (White) □ Latino or Hispanic
   □ Other_____ □ Declined

If you are a Medicare beneficiary, you are required by Medicare to answer question 4:

4. Do you consume more than 7 alcoholic drinks in a week? □ YES □ NO
5. Please mark boxes below as appropriate:

Please Mark One Box For Each Item	No	>1 year	<1 Year	Please Mark One Box For Each Item	No	>1 year	<1 year
Alzheimer's	□	□	□	Muscular Dystrophy	□	□	□
Cardiovascular Disease	□	□	□	Multiple Sclerosis	□	□	□
Cerebral Vascular Accident (Stroke)	□	□	□	Numbness/tingling	□	□	□
Current Infection	□	□	□	Obesity	□	□	□
Degenerative Joint Disease	□	□	□	Osteoarthritis	□	□	□
Diabetes Mellitus Type 1	□	□	□	Osteoporosis	□	□	□
Diabetes Mellitus Type 2	□	□	□	Pace Maker	□	□	□
Dizziness/Faintness	□	□	□	Parkinson's	□	□	□
Fibromyalgia	□	□	□	Peripheral Neuropathy	□	□	□
Fracture or Suspected Fracture	□	□	□	Rheumatoid Arthritis	□	□	□
High Blood Pressure	□	□	□	Seizures	□	□	□
History of Cancer	□	□	□	Spinal Cord Injury	□	□	□
Immunosuppression				Skin Disease	□	□	□
Lupus	□	□	□	Traumatic Brain Injury	□	□	□
Metal Implants	□	□	□	Other…….. (See Below)	□	□	□

Please specify if you have checked "Other" above: _____

_____

_____

Do you have Allergies? YES or NO Please specify _____