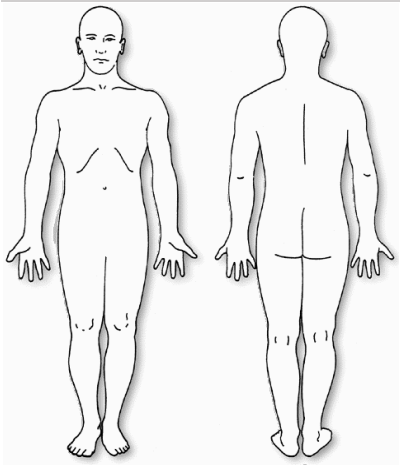
Catherine Mormile DPT, doctor of Physical Therapy, LLC
New Patient Information Sheet

Welcome to our practice!

Please help us serve you better by taking a few minutes to provide the following information.

Name:					Today's date:				
	Last Name		First Name						
Address:									
City / State / ZIP:									
Phone #	MOBILE:		HOME:		WORK:				
DOB:			Age:		Marital status:	M	S	W	D
Email:									
Occupation:			Employer:						
Emergency Contact-	Name:		Phone:						
Dentist-	Name:		Orthotic/Mouth guard? Bridge? Dentures? Implant(s)? Tooth loss?						
Primary care physician-	Name:		CPAP /breathing devise?						

Brief medical history: → → →	
Current medications, including vitamins and supplements: →	
What is the primary issue/problem that brings you in today?	Please shade in areas where you have pain, discomfort, or tension, whether related to your jaw complaint or not.
	
Secondary concern/problem?	
As a result, I am now having difficulty with:	
As a result of these symptoms are you having pain? On scale 0-10, what is your pain (worst & best)? What does it feel like?	
When did your symptom(s) begin? (Date):	

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Patient Goals

Please list the activities that you would like to be able to do as a result of therapy.

Task / Activity	Duration / How Often	By When
Other Goals?		

Informed Consent

I understand that Catherine Mormile DPT, doctor of Physical Therapy,LLC will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, evaluating the quality of services provided and any administrative operations related to treatment or quality of service.

I do hereby agree and give my consent for Catherine Mormile DPT, doctor of Physical Therapy, LLC to furnish care and treatment that is considered necessary and proper in the diagnosing or treating of my physical condition.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.
I hereby certify that all the above information is true to the best of my knowledge.

Patient/Parent/Guardian Signature:_____

***Date:*_____**