



**Judith R. Peterson, M.D., P.C. dba SoDak Rehab**

5023 South Bur Oak Place  
Sioux Falls, SD 57108-2228

Telephone: 1-605-361-3945 • Fax: 1-605-361-2128  
sodakrehab.com

Legal Name: \_\_\_\_\_ Date: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Occupation (if retired former job(s)): \_\_\_\_\_

Hand Dominance: Right/Left/Both \_\_\_\_\_

Height \_\_\_\_\_ ft Weight \_\_\_\_\_ lbs

Referred by (check one): Self \_\_\_\_\_ Family \_\_\_\_\_ Friend \_\_\_\_\_

Doctor/Other Health Care Professional: \_\_\_\_\_

Name of general medical care physician(s): \_\_\_\_\_

**PRESENT HISTORY:**

Please briefly describe your problem(s): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date of accident or onset of symptoms: \_\_\_\_\_

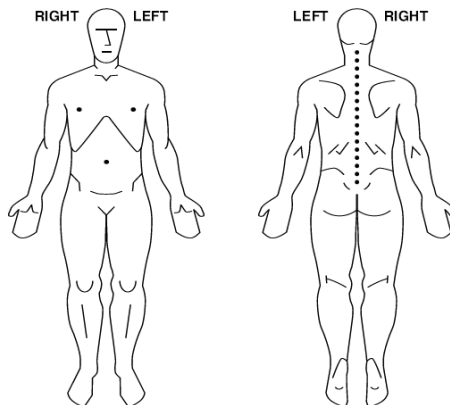
Do you believe your problem(s) to be work related or due to accident or injury? If yes, please describe: \_\_\_\_\_

What makes your symptoms better? \_\_\_\_\_

What makes your symptoms worse? \_\_\_\_\_

**PAIN/SYMPTOM DIAGRAM:**

Please mark the parts of the body where you feel the problem:



**PREVIOUS MEDICAL CARE or DIAGNOSTIC TREATMENT for PRESENT PROBLEM:**

Primary Care Dr \_\_\_\_\_

Specialists \_\_\_\_\_

Chiropractor \_\_\_\_\_

Physical Therapy \_\_\_\_\_

Medications \_\_\_\_\_

Injections \_\_\_\_\_

Other Treatment \_\_\_\_\_

Other Testing \_\_\_\_\_

Lab Work (Blood Testing) \_\_\_\_\_

X-Ray \_\_\_\_\_

MRI/CT Scan \_\_\_\_\_

Myelogram \_\_\_\_\_

Bone Scan \_\_\_\_\_

EMG/Nerve Conduction \_\_\_\_\_

Ultrasound \_\_\_\_\_

Bone Density Test \_\_\_\_\_

Biopsy \_\_\_\_\_

**PAST MEDICAL HISTORY**

Please list all previous operations, illnesses, injuries, or hospitalizations:

	What	Year	Surgeon/ Hospital
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

Do you use a cane / walker / wheelchair / other? \_\_\_\_\_

Do you have a ventricular defibrillator or pacemaker? \_\_\_\_\_



## ALLERGIES

Please list any medication allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list seasonal or environmental allergies: \_\_\_\_\_  
\_\_\_\_\_

Please list any anesthesia problems: \_\_\_\_\_  
\_\_\_\_\_

## SOCIAL HISTORY:

Marital Status: (circle) Never Married / Married / Widowed / Separated / Divorced

Do you smoke or chew tobacco: Yes / No / Quit How much? \_\_\_\_\_ How Long ? \_\_\_\_\_

Do you drink alcohol? Yes / No / Quit when? \_\_\_\_\_

How many drinks per day? \_\_\_\_\_ beer \_\_\_\_\_ wine \_\_\_\_\_ mixed drinks

## FAMILY MEDICAL HISTORY: please circle appropriate answers

Mother: Alive – Age: \_\_\_\_\_ If deceased cause and age of death \_\_\_\_\_

Father: Alive – Age: \_\_\_\_\_ If deceased cause and age of death \_\_\_\_\_

No. of siblings: \_\_\_\_\_ If deceased cause and age of death \_\_\_\_\_

No. of children: \_\_\_\_\_ If deceased cause and age of death \_\_\_\_\_  
\_\_\_\_\_

## Do any of your blood relatives have the following? Please circle if they do.

Alcoholism

Alzheimer's or other dementia

Asthma

Arthritis

Bleeding Tendency

Cancer

Colitis

Diabetes

Epilepsy

Fibromyalgia

Heart Disease

High Blood Pressure

High Cholesterol

Leukemia

Lupus

Migraine Headaches

Multiple Sclerosis

Muscle disease

Neuropathy

Parkinson's Disease

Rheumatoid Arthritis

Stroke

Thyroid Illness

Tremor

**REVIEW OF SYSTEMS: Please CIRCLE all CURRENT conditions including today's problem:**

GENERAL: weight loss or gain, change in appetite, chills, fever, sweats, swollen glands, excessive sleepiness, insomnia, fatigue

ENDOCRINE: blood sugar too high or too low, cold or heat intolerance, menopausal symptoms, pregnancy

BLOOD: bleeding tendency, anemia, blood clots, DVT, Pulmonary Emboli (PE), transfusion

EYES: pain, loss of vision, flashing lights, glaucoma, cataracts

EARS/NOSE/MOUTH/THROAT: hearing problem, sinus nosebleeds, sinus discharge, throat or mouth soreness, hoarseness, loud snoring, hearing aid

RESPIRATORY: shortness of breath, cough, wheezing, coughing up blood, asthma

CARDIAC: chest pain, heart palpitations, poor exercise tolerance

DIGESTIVE: constipation, diarrhea, black stool, heartburn (reflux), abdominal pain, gastric bypass surgery

GENITOURINARY: blood in urine, burning on urination, kidney or bladder infection, bladder control problem, sexual problems, vaginal or penile discharge, menstrual irregularities, kidney stones, dialysis, decreased kidney function

MUSCULOSKELETAL: pain in joints, pain in muscles, weakness, joint swelling, backache, broken bones, metal implants, joint replacement surgery, arthritis, morning stiffness, osteoporosis

NEUROLOGICAL: dizziness, tremor, tingling, numbness, paralysis, imbalance, memory loss, headaches, facial pain, seizures

SKIN: rashes, open sores, bruising, swelling, inflammation, non-healing skin wound

PSYCHIATRIC: nervousness, mood changes, sleep disturbances, agitation, hallucinations, depression

Other current conditions not listed: \_\_\_\_\_

Patient or Designee \_\_\_\_\_ Date \_\_\_\_\_

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**Insurance Information**  
**Please Complete ALL Questions**

PATIENT LEGAL NAME: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ Birth Date: \_\_\_\_\_

ADDRESS: (Box/Street) \_\_\_\_\_

(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

Primary Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Secondary Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Employer/School: \_\_\_\_\_

Referring Dr.: \_\_\_\_\_ Family Dr.: \_\_\_\_\_

Is treatment related to an accident?  Y  N If Yes:  Auto  Work  Other: \_\_\_\_\_

Onset of symptoms/date of injury: \_\_\_\_\_ Body Part Injured: \_\_\_\_\_

Explain accident/injury: \_\_\_\_\_

Will an attorney be contacting us for information?  Y  N

If Yes: Name & Telephone of Attorney: \_\_\_\_\_

Primary Ins/Work Com: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

Policy #/Claim #: \_\_\_\_\_ Group #: \_\_\_\_\_ Insured's Soc. Sec. #: \_\_\_\_\_

Patient relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Employer of Insured: \_\_\_\_\_ Employer Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Secondary Ins: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

Policy #/Claim #: \_\_\_\_\_ Group #: \_\_\_\_\_ Insured's Soc. Sec. #: \_\_\_\_\_

Patient relationship to insured:  Self  Spouse  Child  Other: \_\_\_\_\_

Employer of Insured: \_\_\_\_\_ Employer Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Name of Spouse/Closest Relative: (Minors list both parents) \_\_\_\_\_

Address/Phone: \_\_\_\_\_

I authorize Judith R. Peterson, M.D., P.C. dba SoDak Rehab to release medical information to determine benefits payable under this claim. I authorize benefits to be paid directly to Judith R. Peterson, M.D., P.C. I also understand that I am financially responsible for this bill regardless of insurance coverage. I hereby authorize Judith R. Peterson, M.D., P.C. dba SoDak Rehab to release my medical records should I be referred to another physician.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_