

Patient Forms

Patients are responsible for:

Insurance deductible and co-insurance or co-payment per office visits.

At the time of your visit please have:

(1) Current insurance card (2) Picture I.D. (3) Prescription for Physical Therapy from a referring physician.



PATIENT INFORMATION **EMAIL ADDRESS:** _____

First Name:		Last Name:		Middle Initial:	Date: / /
Address:			City:	State:	Zip:
Birth date: / /	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female		S.S. #:	- -
Home Phone: () -		Alternative Phone (Cell, Pager): () -		Spouse:	
Chose Clinic Because/ Referred to Clinic By <input type="checkbox"/> Dr.: <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Family <input type="checkbox"/> Friend					
<input type="checkbox"/> Former Patient <input type="checkbox"/> Close to Work/Home <input type="checkbox"/> Website <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Street Sign <input type="checkbox"/> Other:					

WORK INFORMATION

Employer:	Work Phone () -	Ext.
Occupation:	Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed	

CARE PROVIDER INFORMATION

Referring Dr:	Referring Dr. Phone: () -
Regular Dr./PCP	Regular Dr./PCP Phone: () -

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance Name:	
Subscriber's Name (If different):	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:	
Name of Secondary Insurance:	
Subscriber's Name:	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:	

AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)

Insurance Name: <input type="checkbox"/> Auto : <input type="checkbox"/> Labor & Industries:	
Adjuster/Claim Manager:	Phone: Ext.:
Address:	City: State: Zip:
Claim #:	Accident Date: / / Cause:

ATTORNEY INFORMATION

Name:	Law Firm:	Phone: () -
Address	City	State: Zip:

IN CASE OF EMERGENCY

Name of Local Friend or Relative (Not Living at Same Address):		
Relationship to Patient:	Home Phone: () -	Work Phone: () -

I authorize my insurance benefits be paid directly to Practice Name. I understand that I am financially responsible for any balance. I also authorize _____ to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE

DATE



PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE		YES	NO	JOINT CONDITIONS		YES	NO
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Normal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremity Dislocation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE		YES	NO	OTHER CONDITIONS		YES	NO
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerotic Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MUSCLE CONDITION		YES	NO	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carpal Tunnel R/L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tennis Elbow R/L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back/Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Eyesight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limited Limb Movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LUNGS		YES	NO	Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____			
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Low	<input type="checkbox"/> Smoking	Packs a Day _____
<input type="checkbox"/> 1-2 x Week	<input type="checkbox"/> Standing	<input type="checkbox"/> Medium	<input type="checkbox"/> Alcohol	Drinks a Week _____
<input type="checkbox"/> 3-4 x Week	<input type="checkbox"/> Light Labor	<input type="checkbox"/> High	<input type="checkbox"/> Coffee/Soda	Cups a Week _____
<input type="checkbox"/> 5+ x Week	<input type="checkbox"/> Heavy Labor			

What types of exercise do you perform? : _____

What things cause stress in your life? : _____

Are you taking any seizure medication? YES NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

YES NO If yes list name: _____

List all medications you a currently taking: _____

List all surgeries in the past two years (Including dates): _____

Are you pregnant? YES NO What week?: _____

Have you had any injuries related to work? YES NO If yes list body part and date.: _____

Have you had any Auto Accidents YES NO If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? YES NO Where: _____

Signature of Patient, Parent, Guardian, Personal Representative

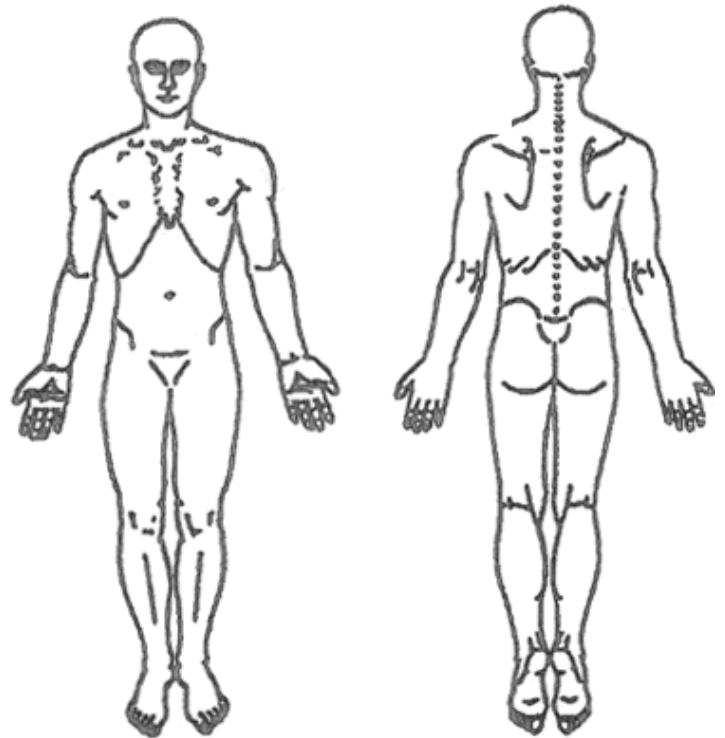
Date

Pain and Symptom Status Report

Name: _____

Date: _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing



- | | | |
|--|---------------------------------------|--|
| <p>Ache
MMM
M</p> | <p>Burning

---</p> | <p>Numbness
O O O O
O O O</p> |
| <p>Pins and Needles
□ □ □ □ □ □ □ □
□ □ □ □ □ □ □ □</p> | <p>Stabbing
/////</p> | <p>Other
xxxx
xxx</p> |

Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____

Date First Symptom of your problem occurred on: _____

2nd Complaint: _____

3rd Complaint: _____

Please circle on the scale below to indicate your <u>CURRENT</u> level of pain:												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it
Please circle on the scale below to indicate your <u>AVERAGE</u> level of pain:												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it
Please circle on the scale below to indicate your <u>WORST</u> level of pain:												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it

Additional Comments: _____

HISTORIA MEDICA

Nombre : _____

fecha: _____ / _____ / _____

Historia pasada (Ha tenido alguna vez?)

Marque donde corresponda

Fiebre reumática/ Murmullo de corazón	
Presión Alta	
Problemas Cardíacos	
Enfermedad de las Arterias	
Vena Várise	
Enfermedad Pulmonar	
Lesiones de Espalda	
Epilepsia	
Diabetes	
Gota	
Cirujías	

Historia Familiar

Alguien de su familia inmediata o abuelos ha tenido?

Ataques al Corazón	
Presión Alta	
Colesterol	
Derrame/Infarto	
Diabetes	
Enfermedad Cardíaca Congénita	
Cirujías del Corazón	
Muerte Prematura	
Otras:	

Sintomas Actuales (Ha tenido recientemente ?)

Dolor en el pecho/Molestia	
Dificultad para Respirar	
Palpitaciones	
Tos o flema	
Tos de Sangre	
Dolor de espalda	
Artritis/Inflamación, Rigidez, Dolor de Coyunturas	
Problemas Ortopédicos	
Explique Por Favor:	
Se levanta al baño varias veces en la noche ?	
Explique Por Favor:	

Medicamentos (Que esta tomando o prescritas)

Preparaciones Digitales
Anti-Arrítmicas (Quidine, Procaine, Amides)
Diuréticos & Electrolitos
Tranquilizantes o Sedantes
Metabólicos - Insulina, Tiroides
Otros Medicamentos:
Tiene alergias a -
Por favor haga una lista de comidas y bebidas que le producen alergias

Factores de Riesgo

Si Ud Fuma, Marque Donde Corresponda.	Tiene Algún Tipo de Actividad Física?
Cigarrillos Tabaco Pipa	Cual?
Cuantos Por Día ? Por Cuantos Años?	Con Qué Frecuencia?
Cual Es Su Peso actual ?	Cuanto Tiempo Se Ejercita Por Día? (por favor marque una)
Qué Tipo de Ocupación Tiene? (Por favor marque una)	Nada 15-30min. 30-45min.
Sedentaria Activa Inactiva trabajo pesado	45-60min. 60-75min. 75-90min.
MARCAPASOS (marque una) SI / NO	