

## 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.



<b>PATIENT INFORMATION</b>	<b>EMAIL ADDRESS:</b> _____
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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:			

<b>WORK INFORMATION</b>
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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	

<b>CARE PROVIDER INFORMATION</b>
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Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -

<b>INSURANCE INFORMATION</b>	<b>( PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST )</b>
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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:	

<b>AUTO OR WORK INJURY CLAIM</b>	<b>( PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP )</b>
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Insurance Name: <input type="checkbox"/> Auto : <input type="checkbox"/> Labor & Industries:	
Adjuster/Claim Manager:	Phone: Ext.:
Address: City: State: Zip:	
Claim #:	Accident Date: / / Cause:

<b>ATTORNEY INFORMATION</b>
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Name:	Law Firm:	Phone: ( ) -
Address		City: State: Zip:

<b>IN CASE OF EMERGENCY</b>
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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 \_\_\_\_\_

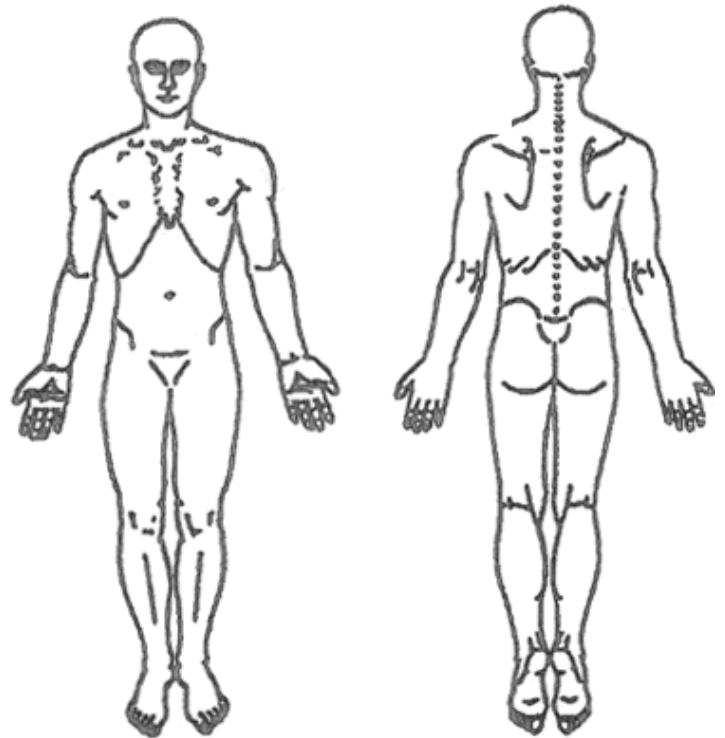
Date \_\_\_\_\_

## 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



<b>Ache</b>	<b>Burning</b>	<b>Numbness</b>
MMM	— — —	○ ○ ○ ○
M	— —	○ ○ ○

<b>Pins and Needles</b>	<b>Stabbing</b>	<b>Other</b>
□ □ □ □ □ □ □ □	/// ///	x x x x
□ □ □ □ □ □ □ □	///	x x x

### Chief Complaint and Visual Analog Scale

My Chief Complaint is: \_\_\_\_\_

Date First Symptom of your problem occurred on: \_\_\_\_\_

2nd Complaint: \_\_\_\_\_

3rd Complaint: \_\_\_\_\_

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

<b>Si Ud Fuma, Marque Donde Corresponda.</b>	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.
<b>MARCAPASOS (marque una)      SI / NO</b>	