



PATIENT INFORMATION

Patient's Name _____ Driver's License # _____

Custodial Parent/Guardian _____ Lives with Mother Father Other _____

SSN _____ Birth date _____ Sex: Male Female Marital Status _____

Address _____

Home Phone _____ Cell Phone _____ City _____ State _____ Zip code _____

Email Address _____

Patient's Employer _____ Work Phone _____

RESPONSIBLE PARTY (If other than patient)

Name _____ Home Phone _____ Work Phone _____

Address _____

City _____ State _____ Zip code _____

Employer _____ Employer's Address _____

PRIMARY & SECONDARY INSURANCE

1) Insurance Company's Name _____ Effective Date _____

Subscriber's Name _____ Subscriber's D.O.B. _____ Subscriber's SSN _____

Subscriber's Employer _____ Subscriber's Group & Policy # _____

2) Insurance Company's Name _____ Effective Date _____

Subscriber's Name _____ Subscriber's D.O.B. _____ Subscriber's SSN _____

Subscriber's Employer _____ Subscriber's Group & Policy # _____

INJURY INFORMATION

Date of Injury: _____ Employment Related? Yes No Auto Accident? Yes No

Cause: _____

Case Manager Name: _____ Case Manager Phone: _____

Vocational Counselor/Nurse Case Manager: _____

EMERGENCY NOTIFICATION (Someone not living with you)

Name	Relationship	Phone (Day & Night)
_____	_____	_____
Address	City	State Zip code
_____	_____	_____

Primary Care Physician _____ Phone _____

REFERRED TO THIS OFFICE BY _____

I hereby authorize my insurance benefits to be paid directly to the provider of these services. I am financially responsible for any balance due, including services that are not covered by my insurance plan. I authorize the doctor or the insurance company to release information required to process the claim or provide continuity of care.

Signature _____ Date _____

Patient or Guardian

Print _____

Revised April 2011

MEDICAL PROFILE QUESTIONNAIRE

Please fill out the following questionnaire as completely as possible. This enables your therapist to design a safe and appropriate treatment plan for you. Your input is very important.

Last Name: _____ First Name: _____ Middle Initial: _____

Age: _____ Height: _____ Weight: _____ Gender: Male Female

Date of Onset: _____ Description of injury/illness: _____

Onset due to: _____

Onset speed: Gradual Sudden Recent symptom trend: Better Worse No Change

Diagnostic Testing Completed: x-ray MRI CT Scan Bone Scan Bone density EMG/NCV Blood work

Primary symptoms: _____

Do you have any of the following? (*Check all that apply*)

- | | |
|--|---|
| <input type="checkbox"/> Tingling or changes in sensation in both arms or both legs | <input type="checkbox"/> Dizziness or Vertigo |
| <input type="checkbox"/> Numbness or tingling around the lips or tongue | <input type="checkbox"/> Facial numbness or tingling |
| <input type="checkbox"/> Loss of balance without loss of consciousness which causes a fall (Drop Attack) | <input type="checkbox"/> Difficulty with bowel or bladder |

PAIN

Location of Pain: _____

Does pain radiate (travel)? Yes No If yes, where: _____

Pain Frequency: Constant/Steady Constant/Variable Intermittent Daily
 Occasional (less than daily) Sporadic (less than weekly)

Pain is aggravated with the following activities or positions: (*Please check all that apply*)

- | | | |
|--|--|---|
| <input type="checkbox"/> Arm and hand activities | <input type="checkbox"/> Driving | <input type="checkbox"/> Quick movements of the head and neck |
| <input type="checkbox"/> Ascending stairs | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Reaching |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Lying on left side | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Climbing ladders | <input type="checkbox"/> Lying on right side | <input type="checkbox"/> Squatting |
| <input type="checkbox"/> Computer use | <input type="checkbox"/> Lying prone | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Crawling | <input type="checkbox"/> Lying supine | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Crouching | <input type="checkbox"/> Overhead activity | <input type="checkbox"/> Work Activities |
| <input type="checkbox"/> Descending stairs | <input type="checkbox"/> Pinching and grasping | |

Pain is alleviated by: (*Please check all that apply*)

- | | | | |
|-----------------------------------|--|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Bending | <input type="checkbox"/> Lying on left side | <input type="checkbox"/> Massage | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Lying on right side | <input type="checkbox"/> Medication | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Ice | <input type="checkbox"/> Lying prone | <input type="checkbox"/> Movement | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Kneeling | <input type="checkbox"/> Lying supine | <input type="checkbox"/> Rest | |

Pain Quality: Aching Burning Stabbing Dull Pulsing Sharp Throbbing

Pain response to time of day: Better in AM Better mid-day Better in evening
 Worse in AM Worse mid-day Worse in evening

Any prior episodes of this problem? Yes No Explain: _____

Any problem sleeping due to the current problem? Yes No

If yes, how many times are you waking during the night? _____

Personal health rating: At the present time would you say your health is: Excellent Good Fair Poor

MEDICATIONS (Please check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Over-the-counter pain medications | <input type="checkbox"/> Medication for high blood pressure | <input type="checkbox"/> Hormones |
| <input type="checkbox"/> Prescription pain medications | <input type="checkbox"/> Heart medication | <input type="checkbox"/> Muscles relaxants |
| <input type="checkbox"/> Anxiety medication | <input type="checkbox"/> Medication for high cholesterol | <input type="checkbox"/> Aspirin/NSAIDS |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Corticosteroids | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Medication for depression | <input type="checkbox"/> Decongestants | |
| <input type="checkbox"/> Other: <i>Please list</i> _____ | | |
| <input type="checkbox"/> See list included in chart. | | |

Do you currently have or have a history of: (Please check all that apply)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> Black outs | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Smoking/Tobacco use |
| <input type="checkbox"/> Bowel or bladder problems | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Infection | <input type="checkbox"/> Thyroid problem |
| <input type="checkbox"/> Bruising easily | <input type="checkbox"/> Frequent falls | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Unexplained weight gain |
| <input type="checkbox"/> Cancer or Tumors | <input type="checkbox"/> Fever | <input type="checkbox"/> Nitroglycerine patch | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Visual Problems |

Dominant Hand: Right Left

Previous treatment for the current problem: (Please check all that apply)

- Physical Therapy Occupational Therapy Massage Therapy Chiropractic Cortisone shot
 Other: _____

FEMALES – Within the past twelve months have you had:

- Mammogram Yes No
Breast exam Yes No
Pelvic exam Yes No

Are you pregnant? Yes No Possibly

MALES – Within the past twelve months have you had:

- Prostate exam Yes No
Testicular exam Yes No

LIFESTYLE

Are you: Generally sedentary Physically active Have you been able to continue? _____

Alcohol use: None Special occasions only 1-2 drinks per day Over 2 drinks per day 1-3 drinks per week

Smoking/Tobacco use: Yes No If yes, how much? _____

Previous surgical history/date(s): _____

PRIOR FUNCTION

Before this injury or episode: (Please check the appropriate statements)

- I was totally independent.
 I needed no help with activities of daily living (ADLs).
 I needed help in performing the following: _____
 I participated in the following sports/activities: _____



MEDICATION LIST

Patient Name: _____

Date: _____

Referring Practitioner: _____

Please list ALL medications (including prescription, over-the-counter, herbals, vitamins, minerals, dietary or nutritional supplements) which you may be taking routinely and/or on an as needed basis.

MEDICATION	DOSAGE	TIMES PER DAY	ROUTE (how taken) Oral, Injection, etc.
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			

This information has been reviewed with the patient (or authorized representative) to confirm accuracy.

Patient's Signature: _____ Therapist Initials: _____



Notice of Privacy Practices & Communication Acknowledgement

I, _____, (patient's name) understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement;
- This organization reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revision notice to the address I've provided if requested.

Our organization may contact you to remind you of any appointments, healthcare treatment options, billing concerns, or other health services that may be of interest to you.

May we contact you at home? Yes No Phone: _____ OK to leave a message? Yes No
 May we contact you at Work? Yes No Phone: _____ OK to leave a message? Yes No
 May we contact you by cell? Yes No Phone: _____ OK to leave a message? Yes No

Comment: _____

Is there anyone we can leave a message with? Yes No (If yes, list their full name and relationship to you below)

Copies of your chart or any other written information are not covered by this authorization. This authorization will remain in effect until revoked in writing.

(Name) (Relationship)

(Name) (Relationship)

Would you like to authorize an individual as your personal representative? This person would have the authority to schedule, confirm or change appointments only. Yes No (If yes, list their full name and relationship to you below)

(Name) (Relationship)

Signature of Patient or Legal Representative Witness

Date

Printed Name of Patient or Legal Representative Witness

Relationship

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- Patient refused to sign
- Communication barrier prohibited obtaining the acknowledgement
- An Emergency situation prevented us from obtaining acknowledgement
- Other (please specify): _____

Employee Signature

Date