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COMPREHENSIVE PHYSICAL THERAPY
PATIENT INFORMATION

☐ New Patient ☐ Return Patient Email: ______________________________

Patient Name: ____

Address: ____
Street # or PO Box City State Zip Code

Date of Birth: __________________ Age: _____ ☐ Male ☐ Female SS#: ___________________

Home Phone: __________________________ Work or Cell Phone: _________________________

Patient Status: ☐ Single ☐ Married ☐ Widowed ☐ Other

ARE YOU CURRENTLY RECEIVING HOME HEALTH SERVICES FOR ANY REASON? ☐ YES ☐ NO
IS THIS INJURY THE RESULT OF A WORK RELATED ACCIDENT?: ☐ YES ☐ NO
IS THIS INJURY THE RESULT OF AN AUTO RELATED ACCIDENT?: ☐ YES ☐ NO

HOW DID YOU HEAR ABOUT US?

☐ Newspaper ☐ Past Patient/Friend ☐ Medical Doctor ☐ Website
☐ Yellow Pages ☐Other___________________________________

DOCTOR/EMERGENCY CONTACT INFORMATION: (required)

Referring Physician: _______________________ Primary Care Physician: _____________________

Date Last Seen: _____________________ Date Last Seen: _____________________

Emergency Contact: ____

Relationship: ___________________________ Phone Number: _________________________

PRIVATE INSURANCE/FINANCIAL RESPONSIBILITY INFORMATION: (required)

Person Financially Responsible: ________________________________ Phone: _________________

Address: ____

Relationship to Patient: ____

Primary Insurance: _____________________ **Secondary Insurance:** _________________________

Policy#: _____________________________ Policy #: _________________________________

Group #: _____________________________ Group #: _________________________________

Is the Patient the Subscriber? ☐ Yes ☐ No **Is the Patient the Subscriber?: ☐ Yes ☐ No**

IF NO PLEASE COMPLETE SECTION BELOW

Subscriber Name: _______________________ **Subscriber Name:** __________________________

SS#: _________________________________ SS#: ___________________________________

Date of Birth: ______________ Date of Birth: ________________

Relationship to Patient: ____________________ Relationship to Patient: _______________________

- CONTINUED -
PLEASE COMPLETE SECOND PAGE

ILLNESS OR ONSET OF PAIN INFORMATION: (required)

□ ILLNESS □ INJURY Date of Injury/Onset of Symptoms: ______________________________

What body part is involved: ____ □ Left □ Right

Injury Occurred: □ Home □ Employment* □ School* □ Recreation* □ Pedestrian* □ MVA/Auto*
□ Other – Briefly explain: ____

***If this is a Workers Comp/Liability/Auto Claim - Please Complete Section Below**

Name of Workers Compensation/Liability/Auto Insurance: ____

State that incident occurred in: ________________________ Claim #: ___________________________________

Insurance Adjusters Name: ____

Phone Number: ___________________________________ Extension Number: _____________________________

Has an Attorney been obtained: □ Yes □ No – If yes please complete below

Attorney Name: ____ Phone: ____________________________

ADDITIONAL INFORMATION: (required)

Employer: ____ Phone: ______________________ □ Retired

Address: ____ Job Description: ___________________________

Are you a student? □ Yes □ No □ Full Time □ Part Time

MEDICAL HISTORY

Please check any medical conditions that we should be aware of:

____ High Blood Pressure ____ Scoliosis/Back Disorder ____ Heart Attack/Heart Problems

____ Diabetes ____ Lung Disorders ____ Blood Disorders

____ Cancer ____ Ulcer/Digestive ____ Arthritis

____ Metal Implants ____ Pacemaker ____ Seizure Disorder

____ Hepatitis C ____ Tuberculosis ____ Vertigo

Are you Pregnant? □ yes □ no

Any Other Conditions/Concerns that we should be aware of?: ____

____

Surgeries and Surgical Dates: ____

____

Medication List Attached: Please complete

ALLERGIES: ____

Have you had any diagnostic testing performed related to your current injury?

□ MRI □ X-ray □ CT Scan □ EMG □ None □ Other: _____________________________________

To the best of my knowledge, the information that I have given is complete and true.

Patient/Guardian Signature: ____ **Date:** _____________

Therapist Signature: ____ **Date:** _____________

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Dizziness Handicap Inventory

INSTRUCTIONS: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your dizziness. Please answer every question. Please do not skip any questions.

1. Does looking up increase your problem? Yes Sometimes No

2. Because of your problem, do you feel frustrated? Yes Sometimes No

3. Because of your problem, do you restrict your travel for business or recreation? Yes Sometimes No

4. Does walking down the aisle of a supermarket increase your problem? Yes Sometimes No

5. Because of your problem, do you have difficulty getting into or out of bed? Yes Sometimes No

6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing, or to parties? Yes Sometimes No

7. Because of your problem, do you have difficulty reading? Yes Sometimes No

8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem? Yes Sometimes No

9. Because of your problem, are you afraid to leave home without having someone with you?
Yes Sometimes No

10. Because of your problem, have you been embarrassed in front of others? Yes Sometimes No

11. Do quick movements of your head increase your problem? Yes Sometimes No

12. Because of your problem, do you avoid heights? Yes Sometimes No

13. Does turning over in bed increase your problem? Yes Sometimes No

14. Because of your problem, is it difficult for you to do strenuous housework or yard work?
Yes Sometimes No

15. Because of your problem, are you afraid people may think you are intoxicated?
Yes Sometimes No

16. Because of your problem, is it difficult for you to go for a walk by yourself?

Yes Sometimes No

17. Does walking down a sidewalk increase your problem? Yes Sometimes No

18. Because of your problem, is it difficult for you to concentrate? Yes Sometimes No

19. Because of your problem, is it difficult for you to go for a walk around your house in the dark?

Yes Sometimes No

20. Because of your problem, are you afraid to stay home alone? Yes Sometimes No

21. Because of your problem, do you feel handicapped? Yes Sometimes No

22. Has your problem placed stress on your relationship with members of your family or friends?

Yes Sometimes No

23. Because of your problem, are you depressed? Yes Sometimes No

24. Does your problem interfere with your job or household responsibilities? Yes Sometimes No

25. Does bending over increase your problem? Yes Sometimes No

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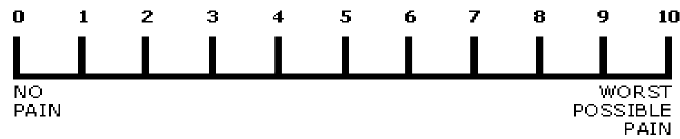
How would you describe your pain today?



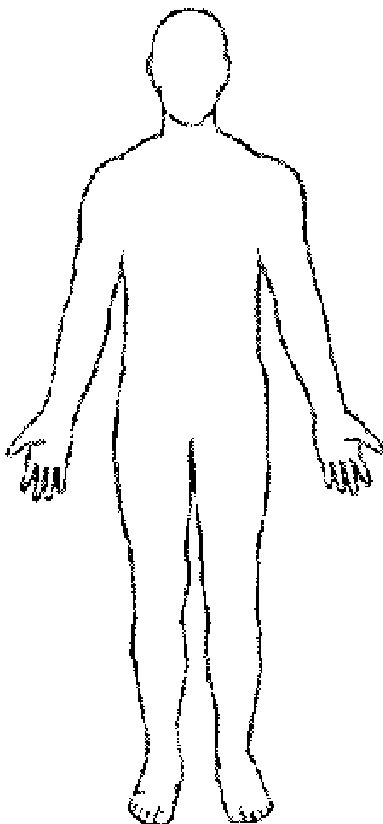
Using the 0 to 10 pain scale, please rate your **least pain** in the past 24 hours: ______

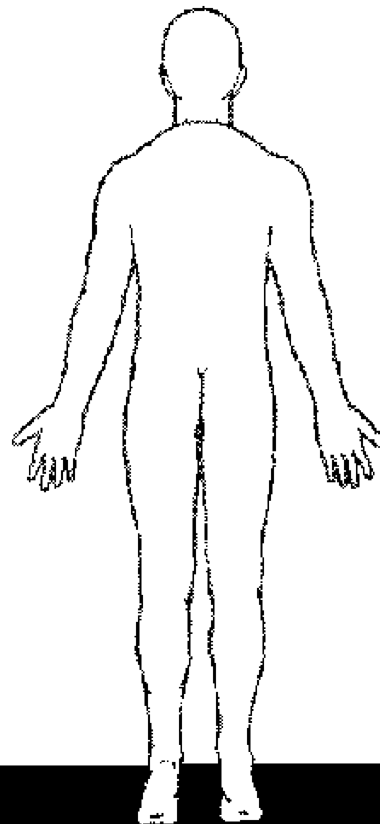
Using the 0 to 10 pain scale, please rate your **worst pain** in the past 24 hours: ______

Are your symptoms – **worse – staying the same – better –** since the onset of symptoms?

Using the key provided please mark on the outlines below where you are experiencing any of the following symptoms:

A – Achiness N – Numbness T – Tingling S- Stiffness H – Throbbing Pain
P – General Painful Feeling





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Patient Name: ____ Date: ____________