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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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Instructions

We are interested in knowing whether you are having any difficulty at all with the activities listed below **because of your lower limb problem** for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, *do you* or *would you* have any difficulty at all with:

	Activities	Extreme difficulty or unable to perform activity	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
1.	Any of your usual work, housework or school activites.	0	1	2	3	4
2.	Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
3.	Getting into or out of the bath.	0	1	2	3	4
4.	Walking between rooms.	0	1	2	3	4
5.	Putting on your shoes or socks.	0	1	2	3	4
6.	Squatting.	0	1	2	3	4
7.	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8.	Performing light activities around your home.	0	1	2	3	4
9.	Performing **heavy** activities around your home.	0	1	2	3	4
10.	Getting into or out of a car.	0	1	2	3	4
11.	Walking 2 blocks.	0	1	2	3	4
12.	Walking a mile.	0	1	2	3	4
13.	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14.	Standing for 1 hour.	0	1	2	3	4
15.	Sitting for 1 hour.	0	1	2	3	4
16.	Running on even ground.	0	1	2	3	4
17.	Running on uneven ground.	0	1	2	3	4
18.	Making sharp turns while running fast.	0	1	2	3	4
19.	Hopping.	0	1	2	3	4
20.	Rolling over in bed.	0	1	2	3	4
	Column Totals:	0	1	2	3	4

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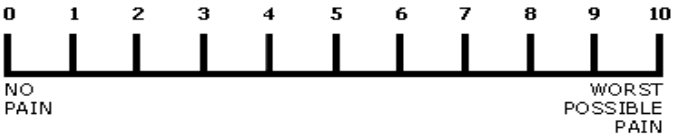
How would you describe your pain today?



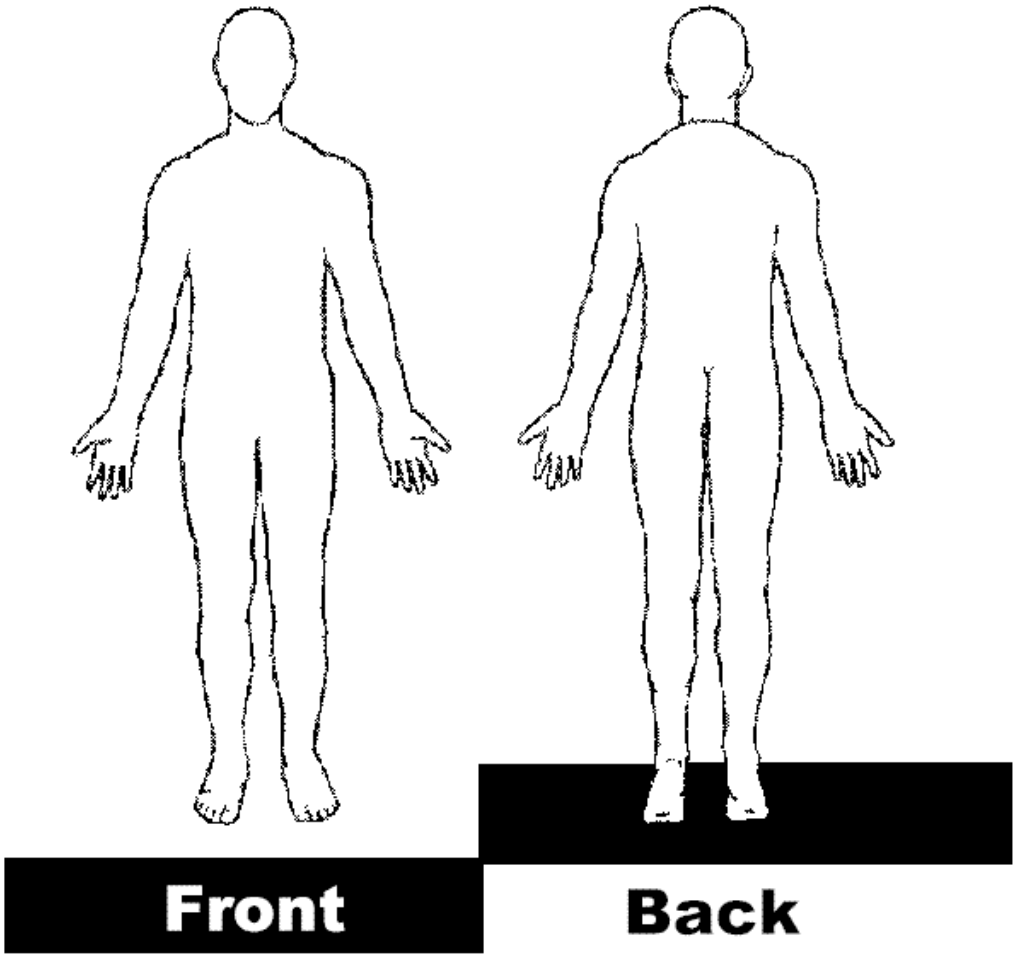
Using the 0 to 10 pain scale, please rate your **least pain** in the past 24 hours: _____

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



Patient Name: _____ Date: _____