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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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NECK PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ*: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE. CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity **A I have no pain at the moment.** **B The pain is very mild at the moment.** **C The pain is moderate at the moment.** **D The pain is fairly severe at the moment.** **E The pain is very severe at the moment.** **F The pain is the worst imaginable at the moment.**	***SECTION 6 - Concentration*** **A I can concentrate fully when I want to with no difficulty.** **B I can concentrate fully when I want to with slight difficulty.** **C I have a fair degree of difficulty in concentrating when I want to.** **D I have a lot of difficulty in concentrating when I want to.** **E I have a great deal of difficulty in concentrating when I want to.** **F I cannot concentrate at all.**
SECTION 2 -Personal Care (Washing, Dressing, etc.) **A I can look after myself normally without causing extra pain.** **B I can look after myself normally, but it causes extra pain.** **C It is painful to look after myself and I am slow and careful.** **D I need some help, but manage most of my personal care.** **E I need help every day in most aspects of self care.** **F I do not get dressed, I wash with difficulty and stay in bed.**	***SECTION 7 - Work*** **A I can do as much work as I want to.** **B I can only do my usual work, but no more.** **C I can do most of my usual work, but no more.** **D I cannot do my usual work.** **E I can hardly do any work at all.** **F I cannot do any work at all.**
SECTION 3 - Lifting **A I can lift heavy weights without extra pain.** **B I can lift heavy weights, but it gives extra pain.** **C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.** **D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.** **E I can lift very light weights.** **F I cannot lift or carry anything at all.**	***SECTION 8 - Driving*** **A I can drive my car without any neck pain.** **B I can drive my car as long as I want with slight pain in my neck.** **C I can drive my car as long as I want with moderate pain in my neck.** **D I cannot drive my car as long as I want because of moderate pain in my neck.** **E I can hardly drive at all because of severe pain in my neck.** **F I cannot drive my car at all.**
SECTION 4 - Reading **A I can read as much as I want to with no pain in my neck.** **B I can read as much as I want to with slight pain in my neck.** **C I can read as much as I want to with moderate pain in my neck.** **D I cannot read as much as I want because of moderate pain in my neck.** **E I cannot read as much as I want because of severe pain in my neck.** **F I cannot read at all.**	***SECTION 9 - Sleeping*** **A I have no trouble sleeping.** **B My sleep is slightly disturbed (less than 1 hour sleepless).** **C My sleep is mildly disturbed (1-2 hours sleepless).** **D My sleep is moderately disturbed (2-3 hours sleepless).** **E My sleep is greatly disturbed (3-5 hours sleepless).** **F My sleep is completely disturbed (5-7 hours)**
SECTION 5 - Headaches **A I have no headaches at all.** **B I have slight headaches which come infrequently.** **C I have moderate headaches which come infrequently.** **D I have moderate headaches which come frequently.** **E I have severe headaches which come frequently.** **F I have headaches almost all the time.**	***SECTION 10 - Recreation*** **A I am able to engage in all of my recreational activities with no neck pain at all.** **B I am able to engage in all of my recreational activities with some pain in my neck.** **C I am able to engage in most, but not all of my recreational activities because of pain in my neck.** **D I am able to engage in a few of my recreational activities because of pain in my neck.** **E I can hardly do any recreational activities because of pain in my neck.** **F I cannot do any recreational activities at all.**

COMMENTS:_____

_____

_____

NAME: _____ **DATE:** _____ **SCORE:** _____

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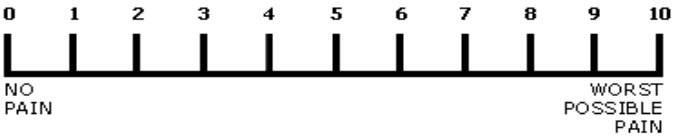
How would you describe your pain today?



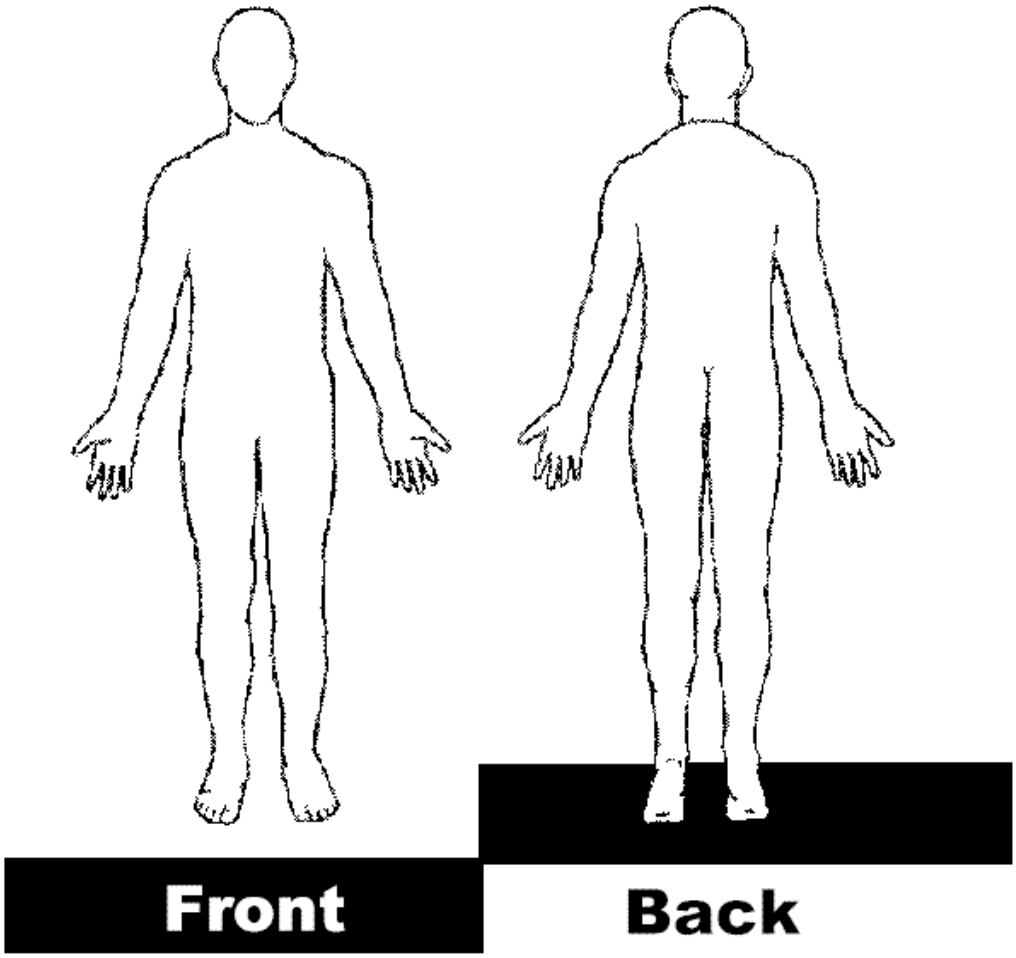
Using the 0 to 10 pain scale, please rate your **least pain** in the past 24 hours: _____

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: _____