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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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LOW BACK PAIN QUESTIONNAIRE

PATIENT NAME: _____ **DATE**: _____

Please read: This questionnaire is designed to enable us to understand how much your low back 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 The pain comes and goes and is very mild.
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate.
D The pain is moderate and does not vary much.
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

SECTION 2 - Personal Care

A I do not have to change my way of washing or dressing in order to avoid pain.
B I do not normally change my way of washing or dressing even though it causes some pain.
C Washing and dressing increases the pain but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of the pain I am unable to do some washing and dressing without help.
F Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 - Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weights at the most.

SECTION 4 - Walking

A I have no pain on walking.
B I have some pain on walking but it does not increase with distance.
C I cannot walk more than one mile without increasing pain.
D I cannot walk more than 1/2 mile without increasing pain.
E I cannot walk more than 1/4 mile without increasing pain.
F I cannot walk at all without increasing pain

SECTION 5 - Sitting

A I can sit in any chair as long as I like.
B I can sit only in my favorite chair as long as I like.
C Pain prevents me from sitting more than one hour.
D Pain prevents me from sitting more than 1/2 hour.
E Pain prevents me from sitting more than 10 minutes.
F I avoid sitting because it increases pain straight away.

SECTION 6 - Standing

A I can stand as long as I want without pain.
B I have some pain on standing but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain.
D I cannot stand for longer than 1/2 hour without increasing pain.
E I cannot stand for longer than 10 minutes without increasing pain.
F I avoid standing because it increases the pain immediately.

SECTION 7 - Sleeping

A I get no pain in bed.
B I get pain in bed but it does not prevent me from sleeping well.
C Because of pain my normal night's sleep is reduced by less than 1/4.
D Because of pain my normal night's sleep is reduced by less than 1/2.
E Because of pain, my normal night's sleep is reduced by less than 3/4.
F Pain prevents me from sleeping at all.

SECTION 8 - Social Life

A My social life is normal and gives me no pain.
B My social life is normal but increases the degree of my pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D Pain has restricted my social life, and I do not go out very often.
E Pain has restricted my social life to my home.
F I have hardly any social life because of the pain.

SECTION 9 - Travel

A I get no pain while traveling.
B I get some pain while traveling, but none of my usual forms of travel make it any worse.
C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D I get extra pain while traveling, which compels me to seek alternative forms of travel.
E Pain restricts all forms of travel.
F Pain prevents all forms of travel except that done lying down.

SECTION 10 - Changing degree of pain

A My pain is rapidly getting better.
B My pain fluctuates but overall is definitely getting better.
C My pain seems to be getting better but improvement is slow at present.
D My pain is neither getting better nor worse.
E My pain is gradually worsening.
F My pain is rapidly worsening.

SIGNATURE: _____

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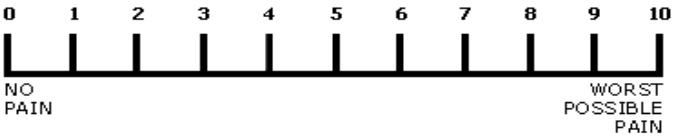
How would you describe your pain today?



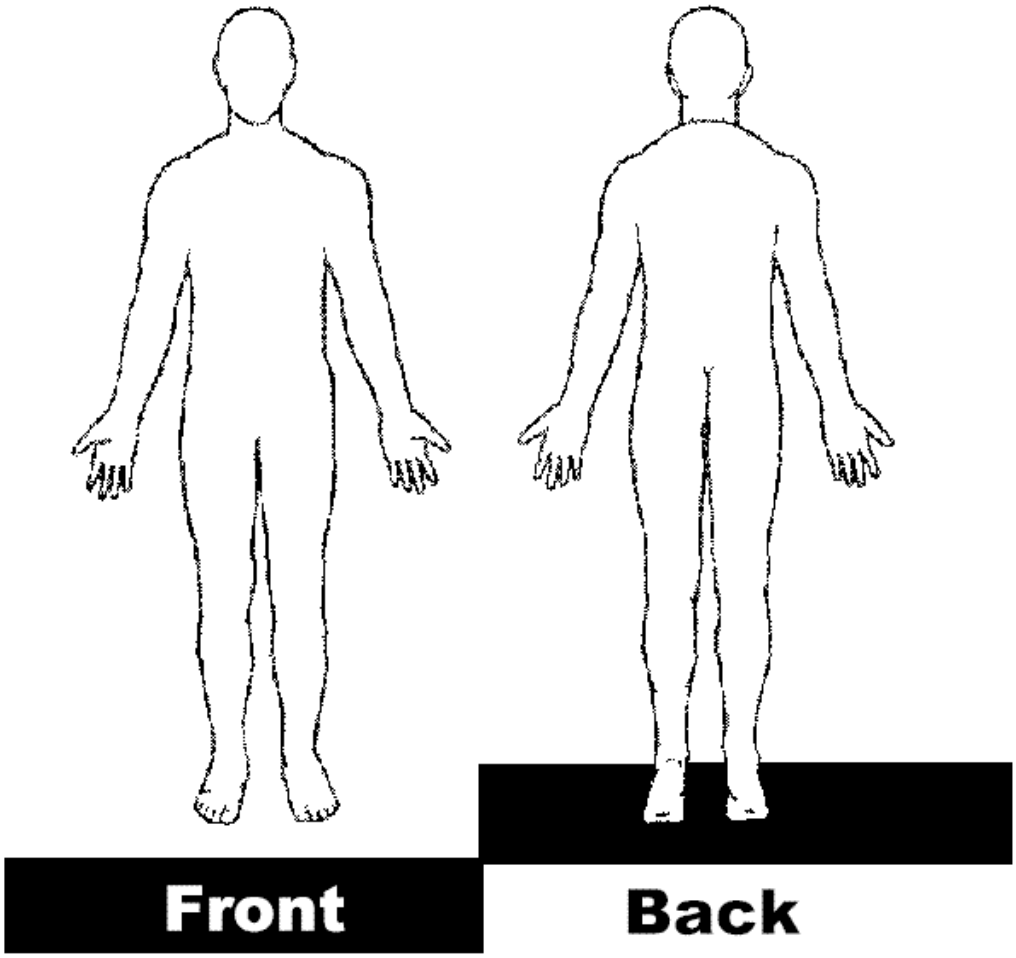
Using the 0 to 10 pain scale, please rate your **least pain** in the past 24 hours: _____

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: _____