

PATIENT INFORMATION

Name: Last: _____ First _____ MI _____ email _____

Address: _____

City: _____ State _____ Zip _____

Home phone: _____ Work _____ Cell _____

Social Security # _____ Drivers License _____

Sex M F Age: _____ Date of Birth: _____ [] Single [] Married [] Widowed [] Divorced

Place of Employment _____ Job Title _____

Address _____

Work Status [] full duties [] modified duties [] unable to work [] unemployed [] disability

Spouses Employment: _____ Emergency Contact # _____

Who can we thank for referring you? _____

Referring Doctor _____

HISTORY OF CURRENT PROBLEM

What is your primary complaint? _____

Do you have a medical diagnosis _____

X- Ray results _____ MRI results _____

When did it start? _____

How did it start? _____

What aggravates it? _____

What makes it better? _____

Is it getting better or worse? [] Better [] Worse [] Comes and Goes [] Constant

Is the condition interfering with [] Work [] Sleep [] Daily routine

What do you believe is wrong with you _____

Do any of the following give you relief? [] Hot pack [] Cold pack [] Medication [] Rest

Other _____

Other areas of pain or concern? _____

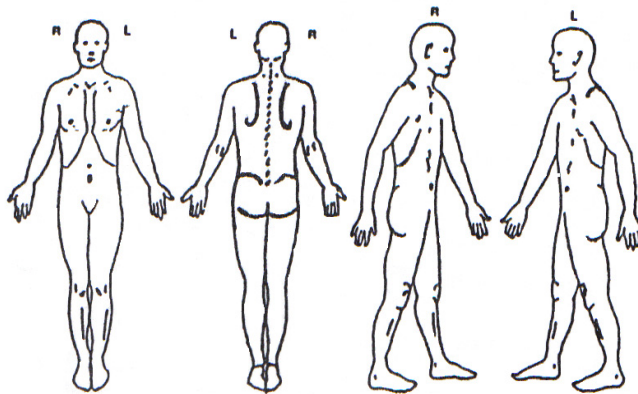
DOES YOUR CURRENT CONDITION CAUSE PROBLEMS OR HAVE YOU HAD TO MODIFY THE WAY YOU PERFORM ANY OF THE FOLLOWING:

- | | | |
|---|---|---|
| <input type="checkbox"/> SLEEPING | <input type="checkbox"/> READING | <input type="checkbox"/> CONCENTRATING |
| <input type="checkbox"/> WORKING | <input type="checkbox"/> WASHING/DRESSING | <input type="checkbox"/> LIFTING |
| <input type="checkbox"/> DRIVING | <input type="checkbox"/> RECREATION | <input type="checkbox"/> STANDING |
| <input type="checkbox"/> WALKING | <input type="checkbox"/> SITTING | <input type="checkbox"/> SOCIAL LIFE |
| <input type="checkbox"/> CLIMBING STAIRS | <input type="checkbox"/> BENDING OVER | <input type="checkbox"/> CARRYING GROCERIES |
| <input type="checkbox"/> REACHING SHELVES | <input type="checkbox"/> OPENING JARS | <input type="checkbox"/> GETTING OUT OF A CHAIR |
| <input type="checkbox"/> TURNING IN BED | <input type="checkbox"/> OPENING A DOOR | <input type="checkbox"/> PREPARING MEALS |
| <input type="checkbox"/> USING A KNIFE AND FORK | <input type="checkbox"/> EXERCISE/PLAY SPORTS | <input type="checkbox"/> CLEANING YOUR HOUSE |

WHAT 3 ACTIVITIES DOES THIS PROBLEM LIMIT YOU IN DOING

WHAT ARE YOUR GOALS FROM PHYSICAL THERAPY

PLEASE MARK ON THE DIAGRAM BELOW WHERE YOU ARE EXPERIENCING YOUR SYMPTOMS



- A=Ache
- B=Burning
- N=Numbness
- P=Pain
- S=Stabbing
- W=Weakness

0 1 2 3 4 5 6 7 8 9 10
no pain excruciating pain

Current pain level ___/10 At best ___/10 At Worst ___/10

DO YOU HAVE ANY PROBLEMS WITH ANY OF THE FOLLOWING?

- | | | |
|--|--|---|
| <input type="checkbox"/> CANCER | <input type="checkbox"/> PINS & NEEDLES | <input type="checkbox"/> ECZEMA/PSORIASIS |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> BLOOD CLOTTING | <input type="checkbox"/> FUNGAL INFECTION |
| <input type="checkbox"/> OSTEOPOROSIS | <input type="checkbox"/> VASCULAR PROBLEMS | <input type="checkbox"/> HEARING PROBLEMS |
| <input type="checkbox"/> BLOOD PRESSURE | <input type="checkbox"/> ASTHMA | <input type="checkbox"/> VISION PROBLEMS |
| <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> METAL IMPLANTS |
| <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> PAIN NOT RELIEVED
BY CHANGE IN POSITION |
| <input type="checkbox"/> STROKE | <input type="checkbox"/> LACK OF SLEEP | |
| <input type="checkbox"/> CURRENT PREGNANCY | <input type="checkbox"/> RINGING IN EARS | OTHER _____ |
| <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> SUDDEN WEIGHT LOSS | _____ |
| <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> LOSS OF MEMORY | |
| <input type="checkbox"/> EPILEPSY/SEIZURES | <input type="checkbox"/> BLADDER TROUBLE | |
| <input type="checkbox"/> HEADACHES | <input type="checkbox"/> BOWEL TROUBLE | |



CURRENT MEDICATION

Name of medication	What is it for?	Frequency (times/day)

OTHER MEDICAL HISTORY

Other medical problems/diagnoses _____

Surgeries/Accidents/Injuries _____

CANCELLATION POLICY

PHYSIOTHERAPY WORKS, LLC WILL BILL YOUR INSURANCE FOR TREATMENT SHOULD YOU HAVE COVERAGE. OTHERWISE WE SHALL ACCEPT \$65 PER HOUR FOR MASSAGE THERAPY OR \$85 FOR EACH PHYSICAL THERAPY SESSION WHEN PAID AT THE TIME OF SERVICE.

I UNDERSTAND THAT 12 HOURS NOTICE IS REQUIRED FOR CANCELLATION OF APPOINTMENTS, AND I WILL BE CHARGED \$35 FOR EACH MISSED APPOINTMENT WHERE PROPER NOTICE WAS NOT GIVEN. THIS CHARGE CANNOT BE BILLED TO YOUR INSURANCE.

CONSENT FOR TREATMENT

I GIVE MY CONSENT TO THE PROVISION OF EXAMINATION, TREATMENTS, THERAPIES, AND SUPPLIES AS ORDERED BY THE THERAPIST AT PHYSIOTHERAPY WORKS, LLC. I AKNOWLEDGE THAT NO GUARANTEE OR ASSURANCE HAS BEEN MADE AS TO THE OUTCOME OF SUCH TRTREATMENTS, PROCEEDURES AND EXAMINATIONS.

PRIVACY POLICY

I HAVE BEEN ISSUED WITH A NOTICE OF PRIVACY PRACTICES (HIPAA NOTICE).

SIGNATURE _____ DATE _____

PRINTED NAME _____

Thank you for taking the time to fill out this form completely.