

PATIENT INFORMATION		EMAIL ADDRESS: _____	
First Name:	Last Name:	Middle Initial:	Date: / /
Address:		City:	State: Zip:
Birth date: / /	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female	S.S. #: - -
Home Phone: () -	Alternative Phone (Cell, Pager): () -		Spouse:
Chose Clinic Because/ Referred to Clinic By <input type="checkbox"/> Dr.: <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Family <input type="checkbox"/> Friend			
<input type="checkbox"/> Former Patient <input type="checkbox"/> Close to Work/Home <input type="checkbox"/> Website <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Street Sign <input type="checkbox"/> Other:			
WORK INFORMATION			
Employer:		Work Phone () -	Ext.
Occupation:	Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed		
CARE PROVIDER INFORMATION			
Referring Dr:		Referring Dr. Phone: () -	
Regular Dr./PCP		Regular Dr./PCP Phone: () -	
INSURANCE INFORMATION		(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)	
Primary Insurance Name:			
Subscriber's Name (If different):			Birth date : / /
ID. #:	Group/Policy #		
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:			
Name of Secondary Insurance:			
Subscriber's Name:			Birth date : / /
ID. #:	Group/Policy #		
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:			
AUTO OR WORK INJURY CLAIM		(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)	
Insurance Name: <input type="checkbox"/> Auto : <input type="checkbox"/> Labor & Industries:			
Adjuster/Claim Manager:		Phone:	Ext.:
Address:		City:	State: Zip:
Claim #:	Accident Date: / /		Cause:
ATTORNEY INFORMATION			
Name:		Law Firm:	Phone: () -
Address		City:	State: Zip:
IN CASE OF EMERGENCY			
Name of Local Friend or Relative (Not Living at Same Address):			
Relationship to Patient:		Home Phone: () -	Work Phone: () -

I authorize my insurance benefits be paid directly to Practice Name. I understand that I am financially responsible for any balance. I also authorize _____ to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE

DATE

PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE			JOINT CONDITIONS		
	YES	NO		YES	NO
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
Normal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremity Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE			OTHER CONDITIONS		
	YES	NO		YES	NO
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerotic Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
MUSCLE CONDITION					
	YES	NO		YES	NO
Carpal Tunnel R/L	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Tennis Elbow R/L	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Back/Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Limited Limb Movement	<input type="checkbox"/>	<input type="checkbox"/>	Poor Eyesight	<input type="checkbox"/>	<input type="checkbox"/>
LUNGS					
	YES	NO		YES	NO
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Low	<input type="checkbox"/> Smoking	Packs a Day _____
<input type="checkbox"/> 1-2 x Week	<input type="checkbox"/> Standing	<input type="checkbox"/> Medium	<input type="checkbox"/> Alcohol	Drinks a Week _____
<input type="checkbox"/> 3-4 x Week	<input type="checkbox"/> Light Labor	<input type="checkbox"/> High	<input type="checkbox"/> Coffee/Soda	Cups a Week _____
<input type="checkbox"/> 5+ x Week	<input type="checkbox"/> Heavy Labor			
What types of exercise do you perform? : _____				
What things cause stress in your life? : _____				

Are you taking any seizure medication? YES NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?
 YES NO If yes list name: _____

List all medications you are currently taking: _____

List all surgeries in the past two years (Including dates): _____

Are you pregnant? YES NO What week?: _____

Have you had any injuries related to work? YES NO If yes list body part and date.: _____

Have you had any Auto Accidents YES NO If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? YES NO Where: _____

Signature of Patient, Parent, Guardian, Personal Representative

Date

Pain and Symptom Status Report

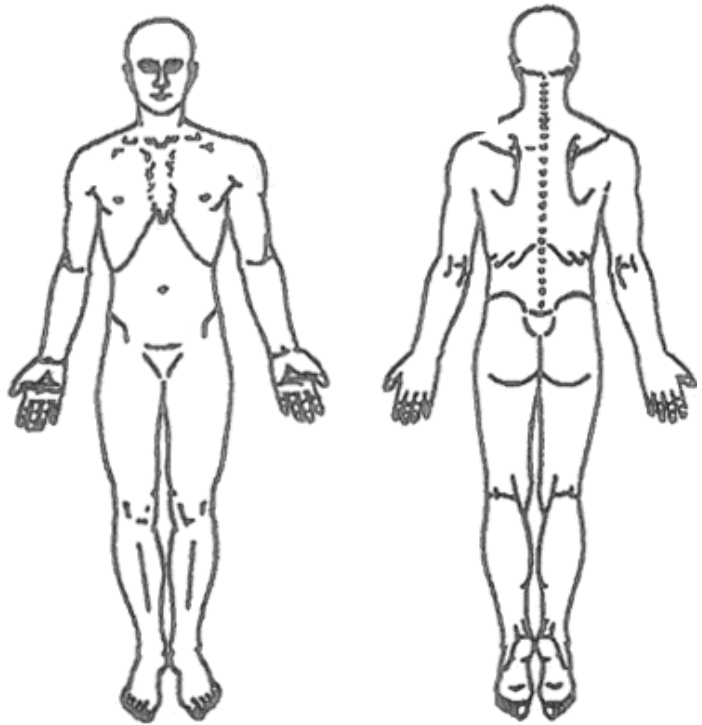
Name: _____

Date: _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing

- | | | |
|--|----------------------|-------------------------|
| Ache
MMM
M | Burning

-- | Numbness
OOOO
OOO |
| Fins and Needles
□□□□□□□□
□□□□□□□□ | Stabbing
///// | Other
xxxx
xxx |



Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____
Date First Symptom of your problem occurred on: _____

2nd Complaint: _____

3rd Complaint: _____

Please circle on the scale below to indicate your <u>CURRENT</u> level of pain:												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it
Please circle on the scale below to indicate your <u>AVERAGE</u> level of pain:												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it
Please circle on the scale below to indicate your <u>WORST</u> level of pain:												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it

Additional Comments _____