PATIENT INFORMATION FORM

***All* Patients or Patients' Legal Representative, please complete all Sections**

(1) Patient: (Full Legal Name or as on Insurance Card)

Primary Language: _____

Name: _____
Last First Initial Sr. Jr.

Address: _____
Street Apt# City State Zip Code

Phone: (_____) _____ - _____ (_____) _____ - _____ (_____) _____ - _____ **Sex: M F**
Home Mobile Work

DOB: _____ **/** _____ **/** _____ **Soc Sec #:** _____ **-** _____ **-** _____ **Marital Status: M / D / S / W / Other**

Email: _____ **Employer:** _____

(2) Emergency Contact

Name: _____
Last First Initial Sr. Jr.

Relationship: _____ **Phone:** (_____) _____ - _____
Home / Mobile / Work (Please Circle)

(3) Doctor Information:

Please provide Doctor who referred you to therapy below:

Name: _____ **Phone: (_____) _____ - _____ Fax: (_____) _____ - _____**
Last, First (MD, DO, DPM, Other)

Please provide your Family/Primary Care Doctor below (if different than above):

Name: _____ **Phone: (_____) _____ - _____ Fax: (_____) _____ - _____**
Last, First (MD, DO, DPM, Other)

(4) Condition to be treated: _____

Is it Related to an Auto Accident? No Yes Date of Accident ____/____/____ State: _____

Is it a Non Work-Related Accident? No Yes Date of Accident ____/____/____ State: _____

Is it a Work-Related Accident? No Yes Date of Accident ____/____/____

If Not Accident Related: Date Condition/Symptoms Began: ____/____/____

Did this Accident/Condition Result in Surgery? No Yes If Yes; Date of Surgery ____/____/____

Do you use: □ Walker/Rolling Walker/Rollator ☐ Cane ☐ Manual Wheelchair ☐ Motorized Wheelchair

If yes to any of the above, what condition necessitates the use of assistance? _____

_____

Have you had PT / OT / Chiropractic Services for this Condition? No Yes (if yes, see below)

Are You Currently Receiving Any Home Health Services? No Yes (if yes, see below)
(ie: Any healthcare worker, aide assisting or doing something to or for you)

If Yes to above: Facility name: _____ Service Type: _____

Approximate Dates Attended: Approximate # of Visits:

COMMERCIAL INSURANCE PAYOR FORM

(5) If Filing Insurance: Check A or B

A. ____ **Patient is the insured** (Skip to Section 7)

B. ____ **Insured is** ___ **Spouse** ____**Parent** (Complete all of Section 6)

(6) Insured Person: (Full Legal Name or as on Insurance Card)

Name: _____
Last First Initial Sr. Jr.

Address: _____
Street Apt# City State Zip Code

Phone: (_____) _____ - _____ (_____) _____ - _____ (_____) _____ - _____ **Sex: M F**
Home Mobile Work

DOB: _____ **/** _____ **/** _____ **Soc Sec #:** _____ **-** _____ **-** _____ **Employed** ___ **Unemployed** ___ **Retired** ___

(7) Employer Information (Please complete if the insured person's employer is the source of benefits)

Employer Name: _____ **Employer Phone** (____) _____ - _____

Address: _____
Street City State Zip Code

(8) Payor Information:

Primary Insurance Company: **Insured is:** _____**Patient** _____**Spouse** _____**Parent**

Ins. Co. Name: _____ **Ins. Ph #**_____

Patient ID/Policy # _____ **Group #** _____

Claims Mailing Address: _____
Street City State Zip Code

Secondary Insurance Company: **Insured is:** _____**Patient** _____**Spouse** _____**Parent**

Ins. Co. Name: _____ **Ins. Ph #**_____

Patient ID/Policy # _____ **Group #** _____

Claims Mailing Address: _____
Street City State Zip Code

(9) Medicare Patients Only: Retirement Date: _____ / _____ / _____

Do you have Traditional Medicare? No Yes

Do you have Rail Road Medicare? No Yes

Are you covered under: ☐ Black Lung Disease ☐ End Stage Renal Disease ☐ Veterans Affairs

☐ Large Group Insurance, if yes Name/Group: _____

PATIENT INFORMATION FORM

(10) Medications: Include All prescriptions, over the counter drugs, herbal and nutritional supplements

Separate List Provided? Yes No If No, please complete this section

Medication/Drug Name	Dosage	Times Per Day

(11) Demographic Information:

Where do you live? ☐ Private Home or Apt ☐ Assisted Living or Group Home ☐ Long-Term Care Facility
☐ Other: _____

Who do you live with? ☐ Alone ☐ Spouse/Significant Other ☐ Child/Children ☐ Group Setting
(check all that apply) ☐ Personal Care Attendant ☐ Other: _____

Employment status: ☐ Full-time, outside home ☐ Full-time, in home ☐ Retired ☐ Unemployed
(check all that apply) ☐ Part-time, outside home ☐ Part-time, in home ☐ Modified duty due to current injury
☐ Not working due to current injury ☐ Other: _____

Does your occupation involve: ☐ Sitting at a computer for prolonged times ☐ Manual Labor ☐ Homemaker
☐ Homemaker with small children ☐ Other: _____

What are your hobbies? _____

Are you currently able to participate at the level and frequency you would like? No Yes

(12) Past Medical History: Height: _____ ft. _____ in. Weight: _____ lbs.

Do you have a Pacemaker? No Yes

Are you a Diabetic? No Yes If yes, for how long? _____

Are you a Smoker? No Yes If yes, for how long? _____

Are you pregnant? No Yes If yes, how many months? _____

In general, how would you rate your overall health right now? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have ever received PT / OT? No Yes If yes, for what condition and what did you like/dislike about treatment?

_____

List All Health Problems, Hospitalizations, Surgeries and Allergies or provide a list to your therapist

_____

_____

_____

_____

PATIENT INFORMATION FORM

THE FOLLOWING QUESTIONS ARE FOR PATIENTS WHO RECENTLY HAD SURGERY AND ARE HERE FOR POST-SURGICAL REHABILITAION. IF YOU HAVE NOT HAD SURGERY, PLEASE SKIP TO PAGE 5.

1. Date of Surgery: ____/____/____

2. Type of Surgery: _____

3. Describe your symptoms prior to surgery: _____

_____

_____

4. How did your symptoms begin prior to surgery: _____

_____

5. Nature of Symptoms:

	Since Surgery		**Prior to Surgery**	
	☐ Sharp	☐ Burning	☐ Sharp	☐ Burning
	☐ Dull Ache	☐ Tingling	☐ Dull Ache	☐ Tingling
	☐ Numb	☐ Shooting	☐ Numb	☐ Shooting

6. How often are Symptoms Experienced?

Since Surgery	**Prior to Surgery**
☐ Constantly (76-100% of day)	☐ Constantly (76-100% of day)
☐ Frequently (51-75% of day)	☐ Frequently (51-75% of day)
☐ Occasionally (26-50% of day)	☐ Occasionally (26-50% of day)
☐ Intermittently (0-25% of day)	☐ Intermittently (0-25% of day)

7. Since your surgery would you report that your symptoms are:

☐ Better ☐ Worse ☐ Same ☐ Improving

8. What is your average pain intensity? Last 24 hours / Past Week / Last 4 Weeks (circle one)

None Unbearable
0 1 2 3 4 5 6 7 8 9 10

9. How much have your symptoms interfered with your work, hobbies or daily activities?

Since Surgery	☐ Not at All	☐ A Little Bit	☐ Moderately	☐ Quite a Bit	☐ Extremely
Prior to Surgery	☐ Not at All	☐ A Little Bit	☐ Moderately	☐ Quite a Bit	☐ Extremely

10. Prior to surgery, who did you see for your symptoms?

☐ No one ☐ Chiropractor ☐ Medical Doctor ☐ Physical / Occupational Therapist

☐ Other:_____

11. What treatment did you receive prior to your surgery and when (approximately)?

_____

12. Prior to surgery, what tests did you have? ☐ XRays ☐ MRI ☐ CT Scan

☐ Other: _____

PATIENT INFORMATION FORM

THE FOLLOWING QUESTIONS ARE FOR PATIENTS WHO ARE HERE AS A RESULT OF AN INJURY, CONDITION OR PAIN (NON-SURGICAL).

1. Describe your current symptoms: _____

_____

_____

2. Did your symptoms begin as a result of a specific injury or gradual onset? ☐ Injury ☐ Gradual Onset

Explain: _____

3. How often are Symptoms Experienced?
   - ☐ Constantly (76-100% of day)
   - ☐ Frequently (51-75% of day)
   - ☐ Occasionally (26-50% of day)
   - ☐ Intermittently (0-25% of day)

4. What is your average pain intensity? Last 24 hours / Past Week / Last 4 Weeks **(circle one)**

None — Unbearable

0 1 2 3 4 5 6 7 8 9 10

5. How much have your symptoms interfered with your work, hobbies or daily activities?

☐ Not at All ☐ A Little Bit ☐ Moderately ☐ Quite a Bit ☐ Extremely

6. How are your symptoms changing?

☐ Improving ☐ Not Changing ☐ Worse

7. Who have you seen for your injury or symptoms?

☐ No one ☐ Chiropractor ☐ Medical Doctor ☐ Physical / Occupational Therapist

☐ Other:_____

8. What treatment have you received for your injury or symptoms and when (approximately)?

_____

_____

9. What tests have you had related to your injury or symptoms? ☐ XRays ☐ MRI ☐ CT Scan

☐ Other: _____