PATIENT INFORMATION FORM

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

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

Preferred Language: _____

Name: _____
Last First Initial Sr. Jr.

Address: _____
Street Apt# City State Zip Code

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

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

Email: _____ **Nickname:** _____

(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: _____

ACCIDENT PAYOR INSURANCE FORM

(5) Auto Accident Claim

Claim will be submitted to: ____ Personal Auto Insurance

Insurance Company: _____ **Claim #:** _____

Adjustor's Name: _____ **Phone # (____) ____-_____ FAX # (____) ____-_____**

Claim Mailing Address:_____
Street City State Zip Code

Claim will be submitted to: ____ Personal Medical Insurance

____ Patient is the Policy Holder (Skip Section 6)

Policy Holder is: ___ Spouse or ____Parent (Complete all of Section 6)

Ins. Co. Name: _____ **Phone (** _____ **)** _____ **-** _____

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

Claims Mailing Address: _____
Street City State Zip Code

(6) Policy Holder: (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) Worker's Compensation Claim

Employer/Company Name: _____

Contact Person/Supervisor: _____ **Ph: (** _____ **)** _____ **-** _____

Address: _____
Street City State Zip Code

____ Employed & Working ____ Employed & Not Working ____ Unemployed Other _____

WC Insurance Co Name: _____**Ph: (** _____ **)** _____ **-** _____

Claims Address: _____
Street Apt# City State Zip Code

Claim # _____ **Adjustor's Name:** _____

Phone: (_____ **)** _____ **-** _____ **Fax: (** _____ **)** _____ **-** _____

PATIENT INFORMATION FORM

(8) 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

(9) 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

(10) 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? _____

Any falls in the past year? No Yes If yes, how many? _____

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: _____

CANCELLATION NO-SHOW POLICY

We strive to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient with a specific therapist in order to minimize your waiting and assure continuity of your treatment.

Your consistent attendance of the planned treatment regimen is paramount to your full recovery. Not attending your scheduled therapy appointments may have adverse effects on your health with potentially long-term negative consequences.

While we are sensitive to the fact that an emergency may occur in a rare instance, cancellations, especially last minute, along with patient no-shows, decrease our ability to accommodate the scheduling needs of the other patients. Cancellations of your appointments should be called during regular business hours but can be left on the voicemail during weekends and holidays or other times of closure.

The details of the policy are:

- *If you are more than 30 minutes late for your appointment and fail to notify us in advance, treatment may be rescheduled.*
- *We ask that all cancellations are called in at least 24 HOURS IN ADVANCE.*
- *Failure to show up for an appointment ("NO SHOW") 3 consecutive times will result in the cancellation of all remaining scheduled appointments.*
- *All cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payor.*
    - *You are responsible for following up with your referring physician if you elect to stop attending your therapy appointments.*

The staff appreciates your anticipated adherence and cooperation with this policy. We wish you the best of luck with your treatment. We are here to help you attain all of your goals and optimize your return to all of your pre-injury activities.

_____ _____

Patient Signature Date