



comprehensive
orthopedic
physical
therapy

Patient Information

Today's Date

Please print and bring to your first appointment

| | | | |
|-------------------------------|-------|---------------------------------|------------|
| Name | | Date of INJURY | |
| Address | | Birth date | |
| City | State | Zip | Home Phone |
| E-mail | | Work Phone | |
| Cell Phone | | Injury Area | |
| In case of emergency, contact | | Phone | |
| Family Physician | | Referring Physician for Therapy | |

Insurance Information

Please provide insurance card for us to copy

| | | | |
|--------------------------------|--|--------------------------|--|
| Policyholder | | Address | |
| Employer | | Policyholder's Signature | |
| Date of birth for policyholder | | Relationship to patient | |
| Group name/number | | Insurance ID # | |
| Date of Injury | | | |
| Insurance Name | | Address | |
| Insurance Phone # | | | |
| Co-pay or percentage | | Deductible | Met for the year? <input type="checkbox"/> |

Worker's Compensation Information

| | | | |
|--------------------------|--|----------------------------------|--|
| Worker's Comp. Claim # | | Date of Injury | |
| Adjuster's name | | Adjuster's phone # | |
| Billing address | | | |
| Workplace contact person | | Phone # | |
| Adjuster's Fax # | | Patient's Social Security Number | |

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Medical History

Primary physical problem _____

Date of onset/accident (**Note:** You must put a date here to ensure insurance payment.) _____

Have you had any radiographs (X-rays), CT scan or MRI reports? _____

Results? _____

Please list your current medications: (*Include inhalers and birth control pills*)

What health measures have you taken?

Please describe your general diet, water and vitamin/supplement intake:

What, if any, techniques do you use for relaxation?

Please provide any additional information you believe to be important for your physical therapy:

Do you have or have you previously had:

Please Explain: when & where?

| | | |
|---|------------------------------|-----------------------------|
| Arthritis | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Broken bones | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Joint pain | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Osteoporosis | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Severe sprains | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Recent weight loss/gain | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Radiating pain in limbs | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Numbness or tingling | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Changes in bowel/bladder | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Heart condition | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| High blood pressure | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Hemophilia | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Pneumonia/asthma or other respiratory problem | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Diabetes | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Cancer | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Cysts or tumors | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Anxiety/panic attacks | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Loss of breath on exertion | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Palpitations/racing heart | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Concussions | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Passing out/dizziness | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Surgery | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Pain with cough/sneeze | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Are you pregnant? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Are you allergic to latex? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you have night pain? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |