SPORT & SPINE PHYSICAL THERAPY PATIENT INFORMATION FORM

(PLEASE PRINT AND COMPLETE IN FULL)

PATIENT NAME_____ DOB____/____/_____SS#_____-_____-_____

ADDRESS_____
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE _____ WORK PHONE_____CELLPHONE_____

EMERGENCY CONTACT NAME _____PHONE #_____
(RELATIONSHIP)

EMAIL ADDRESS _____HOW DID YOU HEAR ABOUT SPORT & SPINE?_____

EMPLOYER NAME _____ OCCUPATION_____

EMPLOYER ADDRESS_____
(STREET) (CITY) (STATE) (ZIP)

IF INJURY IS WORK RELATED, PLEASE FILL OUT THIS SECTION.

CONTACT AT EMPLOYMENT TO VERIFY INJURY_____PHONE#_____EXT_____

DATE OF INJURY_____ BRIEF DESCRIPTION OF INJURY _____

_____ CLAIM #_____

WORKMANS COMP CARRIER_____PHONE #_____EXT_____

IF THE INJURY IS RELATED TO AN AUTO ACCIDENT/PERSONAL INJURY, PLEASE FILL OUT THIS SECTION.

DATE OF INJURY_____ BRIEF DESCRIPTION OF INJURY_____

_____LAWYER'S NAME_____

PHONE #_____MEDPAY/LIABILITY INS_____PHONE #_____

MEDPAY INSURANCE HOLDER_____POLICY #_____

(BY NOT FILLING OUT THE WORK RELATED SECTION OR THE AUTO ACCIDENT/PERSONAL INJURY SECTION, I AM STATING TO THIS OFFICE THAT MY INJURY IS IN NO WAY RELATED TO MY EMPLOYMENT OR IS NOT THE RESULT OF AN AUTO ACCIDENT/PERSONAL INJURY)

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE	ID#	SUBSCRIBER'S NAME	DOB	RELATION TO PATIENT
SECONDARY INSURANCE	ID#	SUBSCRIBER'S NAME	DOB	RELATION TO PATIENT

BY SIGNING THIS FORM, I AM CONFIRMING THAT ALL INFORMATION ON THIS FORM IS ACCURATE AND COMPLETE. I ALSO, UNDERSTAND THAT IF THE PATIENT IS UNDER THE AGE OF 18, I AM SIGNING AS THEIR GUARDIAN/LEGAL GUARDIAN.

SIGNATURE:_____DATE:_____

SPORT AND SPINE PHYSICAL THERAPY
MEDICAL SCREENING FORM

PATIENT NAME_____ DATE_____

CIRCLE YES OR NO...

HAVE YOU OR ANY IMMEDIATE FAMILY MEMBER EVER BEEN TOLD YOU OR THEY HAVE OR HAVE HAD A/AN:

	SELF	FAMILY
CANCER	YES....NO	YES...NO
DIABETES	YES....NO	YES...NO
HIGH BLOOD PRESSURE	YES....NO	YES...NO
HEART DISEASE	YES....NO	YES...NO
ANGINA/CHEST PAIN	YES....NO	YES...NO
STROKE	YES....NO	YES...NO
HEART MURMUR	YES....NO	YES...NO
ABNORMAL HEART RATE	YES....NO	YES...NO
OSTEOPOROSIS	YES....NO	YES...NO
OSTEOARTHRITIS	YES....NO	YES...NO
RHEUMATOID ARTHRITIS	YES....NO	YES...NO

IN THE PAST THREE MONTHS HAVE YOU HAD OR DO YOU EXPERIENCE:

A CHANGE IN YOUR HEALTH	YES...NO
NAUSEA/VOMITING	YES...NO
FEVER/CHILLS/NIGHT SWEATS	YES...NO
UNEXPLAINED WEIGHT CHANGE	YES...NO
NUMBNESS OR TINGELING	YES...NO
CHANGES IN APPETITE	YES...NO
DIFFICULTY SWALLOWING	YES...NO
CHANGES IN BLADDER/BOWEL FUNCTION	YES...NO
SHORTNESS OF BREATH	YES...NO
DIZZINESS	YES...NO
UPPER RESPIRATORY INFECTION	YES...NO
URINARY TRACT INFECTION	YES...NO
ABDOMINAL PAIN OR PROBLEM (ULCER, HEARTBURN, HIATUS HERNIA, OR GALL BLADDER PROBLEM)	YES...NO
PAIN AND DIFFICULTY WITH JAW MOVEMENT	YES...NO
PULSATING HEADACHE	YES...NO
FAINTING OR BLACKOUT EPISODE	YES...NO
DOUBLE VISION OR BLURRED VISION	YES...NO
RINGING SOUND IN EARS	YES...NO
PROBLEMS WITH BALANCE	YES...NO

DATE OF LAST PHYSICAL EXAMINATION_____

THERAPIST'S SIGNATURE_____

CIRCLE YES OR NO...

DO YOU HAVE A HISTORY OF:

ALLERGIES	YES...NO
HEADACHES	YES...NO
BRONCHITIS	YES...NO
KIDNEY DISEASE	YES...NO
RHEUMATIC FEVER	YES...NO
ULCERS	YES...NO
SEXUALLY TRANSMITTED DISEASE	YES...NO
SEIZURES/EPILEPSY	YES...NO
ANXIETY,DEPRESSION,ETC..	YES...NO
PAST OR RECENT TRAUMA (MVA, INJURY TO NECK OR HEAD)	YES...NO
FRACTURES	YES...NO

ARE YOU CURRENTLY:

UNDER STRESS	YES...NO
PREGNANT	YES...NO
DEPRESSED	YES...NO

ARE YOUR SYMPTOMS: (CHECK)

__GETTING WORSE __SAME__IMPROVING

HOW ARE YOU SLEEPING?

__FINE__MODERATE DIFFICULTY

__ONLY WITH MEDS

CHECK ALL THAT APPLY...
DO YOU HAVE A PROBLEM WITH...

__HEARING__VISION__SWALLOWING

__SPEECH__COMMUNICATION

DO/HAVE YOU SMOKED TOBACCO?

IF YES, _____PACKS X _____YEARS

LAST TOBACCO USE_____

DO YOU DRINK ALCHOHOL? YES...NO

HOW MANY PER WEEK?_____

PLEASE SEE REVERSE SIDE....

PATIENT'S NAME_____ DATE_____

LIST CURRENT MEDICATIONS:_____

_____

_____

LIST OF SURGERIES (PLEASE LIST ALL SURGERIES AND APPROX DATES):_____

_____

_____

DIAGNOSTIC TESTS AND APPROX DATES (LIST THOSE ADMINISTERED FOR YOUR CURRENT PROBLEM ONLY)

_____XRAY_____CT SCAN_____MRI_____BONE SCAN_____

_____EMG_____BLOOD CHEMISTRY_____MYELOGRAM_____OTHER_____

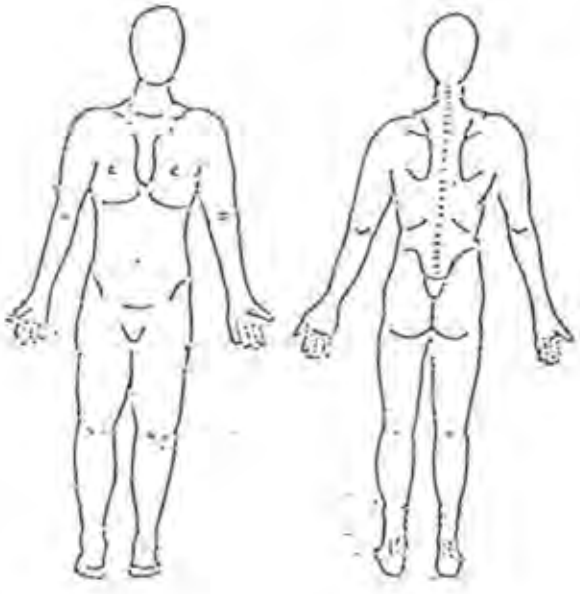
HAVE TOU SEEN ANYONE ELSE FOR YOUR CURRENT PROBLEM?

_____PHYSICIAN_____CHIROPRACTOR_____PODIATRIST_____PHYSICAL THERAPIST

_____ORTHOPEDIC_____DENTIST_____OTHER

PLEASE USE THE DIAGRAM BELOW TO IN DICATE THE SYMPTOMS YOU HAVE EXPERIENCED OVER THE PAST 24 HOURS. BE VERY PRECISE WHEN DRAWING THE LOCATION OF YOUR PAIN. USE THE KEY TO INDICATE THE TYPE OF SYMPTOMS>

KEY: PINS AND NEEDLES- OOOO
DEEP ACHE- ZZZZ
STABBING- ////
BURNING-XXXX



PLEASE RATE YOUR CURRENT LEVEL OF PAIN ON THE FOLLOWING SCALE(CIRCLE ONE)

0 1 2 3 4 5 6 7 8 9 10

(NO PAIN) (WORST IMAGINABLE PAIN)

PLEASE RATE YOUR WORST LEVEL OF PAIN IN THE LAST 24 HOURS (CIRCLE ONE)

0 1 2 3 4 5 6 7 8 9 10

(NO PAIN) (WORST IMAGINABLE PAIN)

PLEASE RATE YOUR BEST LEVEL OF PAIN IN THE LAST 24 HOURS (CIRCLE ONE)

0 1 2 3 4 5 6 7 8 9 10

THERAPIST'S INITIALS_____