SPECIALIZED
PHYSICAL THERAPY

Personal Details

First Name (Legal): ______________________ Last Name (Legal):_________________________

Name Preference: _______________________

Date of Birth: _________________________

Gender on your ID or Insurance Card: ▢ Male ▢ Female

Is your Gender identity different from what is listed on your ID? ▢ No ▢ Yes

Identity/Pronouns: ___________________

Contact Details

Address: ____

City: ___________________________________ State: ____________ Zip Code: _______________

Mobile Phone: ____________________________ Home Phone:_________________________________

Email: __________________________________

Please select how you prefer to receive any patient statements: (Please check off one)

☐ Mail Only ☐ Email Only ☐ Mail & Email

How did you hear about us? (Please check off one)

☐ Doctor ☐ Other Medical Provider ☐ Website

☐ Family/Friend Recommended ☐ Walk-In ☐ Social Media

☐ I am a former patient ☐ Insurance

☐ Google ☐ Community Event

Emergency Contacts:

➢ Name: ____________________________

Phone: ____________________________

Relationship: _______________________

➢ Name: ____________________________

Phone: ____________________________

Relationship: _______________________

Do you have a *Guarantor* for this case that is not yourself? (For minors under 18, please fill in Parent/Guardian's information)

First Name: ___________________________ Last Name: ____________________________

Relationship to Patient:___________________

If the information is different than patient's contact details above please fill in:

Address: ____

City: ________________________________ State: _____________ Zip Code: _______________

Mobile: _______________________ Home: ________________________

Insurance Details

***If the front office has taken a copy of your insurance please skip this**

Primary Insurance Company:

____

Member ID: ____________________________

Patient's Relationship to Insured: ___________

Secondary Insurance Company:

____

Member ID: ___________________________

Patient's Relationship to Insured: __________

Relevant Injury Dates

What date did you first experience symptoms related to your injury? If you do not recall the exact date please provide the closest date when your complaints began.

Onset of symptoms: _____/_____/_____

If you had surgery for this issue, what was the date of the most recent surgery?

Date of Surgery: _____/_____/_____

If you started treatment at another facility on an earlier date, please add that date here.

Date of Treatment: _____/_____/_____

Injury Info

Is your injury work related? If so please describe how your injury occurred:___________________

____

____

Is your injury auto related? If so please describe how your injury occurred:___________________

____

____

Did a doctor/provider refer you to treatment? If yes, please fill in their information:

Full Name of Provider:________________________

Provider Phone: _____________________

Provider Fax: _______________________

Facility Name: _______________________

Facility City: _________________________

Injury Details: (Describe how your condition came to be. What events occurred? When did the symptoms start? How has it progressed over time?)

____

____

____

⭐**Goals List** - Select any of the goals you have for this treatment below. You can add additional goals in the text area below the selections.

- ☐ Return to Normal Mobility
- ☐ Reduce Pain to improve overall function
- ☐ Perform all activities of daily living without pain
- ☐ Walk long distances without pain
- ☐ Stand for prolonged period of time without pain
- ☐ Sit for prolonged period of time without pain
- ☐ Perform flight of stairs without pain and good function
- ☐ Sleep without disturbances or pain
- ☐ Dress independently without pain and improved function
- ☐ Reduce dizziness

Additional Goals:

____

____

Do you have a history of falls and if so, please list the details.

Date of Most Recent Fall: ______/______/______

Details of Fall: ____

____

Medical History

Have you ever suffered from or been told you have any of the following?

- ☐ High Blood Pressure
- ☐ Multiple sclerosis
- ☐ Thyroid problems
- ☐ Cancer
- ☐ Broken bones (fractures)
- ☐ Chronic migraines
- ☐ Heart problems
- ☐ Parkinson's disease
- ☐ Blood disorders
- ☐ Arthritis
- ☐ Other orthopedic problems
- ☐ Lung problems
- ☐ Stroke
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Chronic pain
- ☐ Head injury
- ☐ Liver problems
- ☐ Low blood sugar
- ☐ Circulatory or vascular problems
- ☐ Ulcers/stomach problems
- ☐ Denies of significant medical history

Do you do any of the following? Check if applicable.

- ☐ Smoke
- ☐ Drink alcohol
- ☐ Have any significant family history of illness or disease

Who have you seen for your condition before today?

- ☐ Medical Doctor
- ☐ Massage Therapist
- ☐ Chiropractor
- ☐ Athletic Trainer
- ☐ Physical Therapist
- ☐ Acupuncturist
- ☐ Occupational Therapist
- ☐ Speech Therapist
- ☐ I have not been seen for my condition before today

If you have checked a listed provider(s) above, please describe what they told you or did for your injury: ____

____

____

Please list any medications you are currently taking:
*Please skip if you have given the front desk a copy.

Name of Medication	Dosage	Frequency

If you have additional medications, please add them to a separate sheet.

Please list any known allergies that you have:

____

____

If there's anything else you think we need to know, please include it here:

____

____

____

Pain Measurements

Are you currently experiencing pain? If "yes", please answer the following questions below.
*If "no", please skip this section **and** page 6.*

If there are multiple parts of the body that are in pain please answer for the pain that is causing you the most pain.

Bodypart: _________________

On what side of the body is your injury/condition?

- ☐ Left
- ☐ Right
- ☐ Bilateral
- ☐ Not Applicable

How would you describe your injury's severity?

- ☐ Chronic
- ☐ Acute

What is pain at its **best**, with "0" being the least amount of pain and "10" being the most pain?

0	1	2	3	4	5	6	7	8	9	10

What is the pain at **currently**, with "0" being the least amount of pain and "10" being the most pain?

0	1	2	3	4	5	6	7	8	9	10

What is the pain at its **worst**, with "0" being the least amount of pain and "10" being the most pain?

0	1	2	3	4	5	6	7	8	9	10

How would you describe the pain? Select all options that apply.

- ☐ Burning
- ☐ Sharp
- ☐ Aching
- ☐ Throbbing
- ☐ Shooting
- ☐ Dull
- ☐ Tingling
- ☐ Constant
- ☐ Intermittent
- ☐ Numbness
- ☐ Worse in AM
- ☐ Worse in PM
- ☐ Dizziness

What actions make the pain worse? Select all options that apply.

- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Going upstairs
- ☐ Going downstairs
- ☐ Exercising
- ☐ Bending
- ☐ Reaching/ Extending
- ☐ Lying down
- ☐ Applying Pressure
- ☐ Coughing/ Sneezing
- ☐ Falling

What functions make the pain less? Select all options that apply.

- ☐ Resting
- ☐ Icing
- ☐ Heat
- ☐ Massaging
- ☐ Compression
- ☐ Distraction