3d PT PHYSICAL THERAPY

PATIENT INFORMATION			EMAIL ADDRESS:_____
First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	☐ Male ☐ Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -	Spouse:	
Chose Clinic Because/ Referred to Clinic By ☐ Dr.:		☐ Insurance Plan ☐ Family ☐ Friend	
☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other:			
Complaints:			

WORK INFORMATION		
Employer:	Work Phone ( ) -	Ext.
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION	
Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)	
Primary Insurance Name:	
Subscriber's Name (If different):	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	
Name of Secondary Insurance:	
Subscriber's Name:	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	

AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)			
Insurance Name: ☐ Auto :	☐ Labor & Industries:		
Adjuster/Claim Manager:	Phone:	Ext.:	
Address:	City	State:	Zip:
Nurse Case Manager Name:	Phone: ( ) -	Fax: ( ) -	
Claim #:	Accident Date: / /	Cause:	

ATTORNEY INFORMATION			
Name:	Law Firm:	Phone: ( ) -	
Address	City	State:	Zip:

IN CASE OF EMERGENCY		
Name of Local Friend or Relative (Not Living at Same Address):		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

I authorize my insurance benefits be paid directly to 3DPT. I understand that I am financially responsible for any balance. I also authorize 3DPT to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

3d pt PHYSICAL THERAPY

MEDICAL SCREENING

Date: _____

Name: _____

Gender: M F Age:

Smoker: Y N Pregnant: Y N

Exercise: None 1-2x/wk 3-4x/wk 5+x/wk

What type of exercise?

Past Surgical History (list all & date):

_____

_____

Please List All Current Medications	**Dosage**
_____	_____
_____	_____

Have you had an x-ray, MRI, or other imaging study?

Past Medical History: Please circle each condition that you have been told you have (or had).

Cancer	Diabetes	Kidney Disease	Liver Disease	Stroke
High Blood Pressure	Heart Disease	Angina/Chest Pain	Ulcers	Fibromyalgia
Osteoporosis	Osteoarthritis	Rheumatoid Arthritis	Sexually Transmitted Disease/HIV	
Allergies/Asthma	Lung Disease	Have you had a recent illness (explain if yes)? _____		

Please list any family history of the previous conditions as well: _____

Do you take blood thinners? YES NO Are you allergic to latex? YES NO Other:

During the past month, have you often been bothered by feeling down, depressed, or hopeless? YES NO
During the past month, have you often been bothered by little interest or pleasure in doing things? YES NO
Is this something with which you would like help? YES YES BUT NOT TODAY NO

Currently I am experiencing (circle all that apply):

Fever/chills/sweats	Poor balance (falls)		
Unexplained weight loss	Numbness or Tingling	Changes in appetite	Difficulty swallowing
Depression	Shortness of breath	Dizziness	Headaches
Changes in bowel or bladder function		Nausea /Vomiting	Increased pain at night

CURRENT SYMPTOMS

Where are you currently having symptoms? _____

What date (approximately) did your present pain start?_____

How (gradually, suddenly, injury)?_____

My symptoms are currently: **Getting better / About the same / Getting worse**

Have you received any treatment for this problem?_____

Have you ever had this problem before: **YES / NO**

If so, how was the problem treated?_____

How long did it take for you to feel better? _____

How are you able to sleep at night? ☐ Fine ☐ Moderate Difficulty ☐ Only with medication

What is your personal goal for therapy? _____

CONSENT: To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy services. _____(Sign)

TURN OVER

On the scales below, please circle the number which best represents the severity of your pain.

Average for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

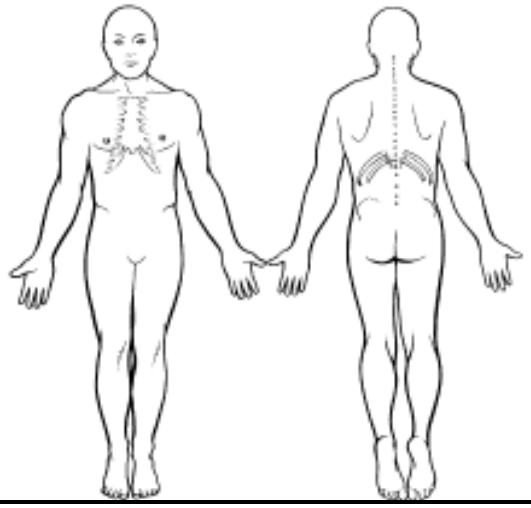
Best for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Worst for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Body Chart:
Please mark the areas where you feel pain on the chart to the right



Therapist Use:
+ / - Cough/Sneeze
+ / - Saddle Anesth.
+ / - Bwl/Bldder Chnge
+ / - Numb/Ting.

Therapist Use:
BP: _____ / _____ mmHg
HR: _____ bpm
RR: _____ bpm

Please circle the activities which make your pain worse:

lying down standing walking stress sitting

Any other activities that make your pain worse? _____

What makes your symptoms better? _____

Please list the best and worst time of day for your symptoms Best - Worst -

Occupation: _____ **Employer:** _____

Currently working? Y N If no, when did you last work? _____

If yes, are your work duties? Full Restricted How many hours/week do you work? _____

Important activities: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below:

1)_____

2)_____

3)_____

Therapist Use:
Rating:_____
Rating:_____
Rating:_____
AVG:_____

Therapist Use

Unable to perform activity 0 1 2 3 4 5 6 7 8 9 10 **Able to perform activity at same level as before your (injury or problem)**