Patient Information

Full Name (First, MI, Last, Suffix)		Sex: ☐ M ☐ F	DOB:
Address:	City:	State:	Zip Code:
Primary Phone: ☐ Home ☐ Cell	Secondary Phone: ☐ Home ☐ Cell	Email Address:	
Emergency Contact Name:	Emergency Contact Phone: _____ Relationship to Patient:	How did you hear about us?	

Referral Information

Name of Referring Physician/Other:	Diagnosis/Body Part: _____	Auto Related? ☐ Yes ☐ No
Name of Primary Care Physician:	Post-Surgical ☐ Yes ☐ No Surgery Date: _____	Work Related? ☐ Yes ☐No

Primary Insurance Carrier / Policy Holder Information

Primary Insurance:		Insurance Identification Number:	
Policy Holder First Name:	Last Name	Sex: ☐ M ☐ F	Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Policy Holder Date of Birth:	Policy Holder SSN	Policy Holder Address:	
Policy Holder Home Phone:		Employer / Employer Address:	

Secondary Insurance Carrier / Policy Holder Information

Secondary Insurance:		Insurance Identification Number:	
Policy Holder Name:		Sex: ☐ M ☐ F	Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Policy Holder Date of Birth:	Policy Holder SSN	Policy Holder Address:	
Policy Holder Home Phone:		Employer / Employer Address:	

Employer Information

Employer Name:	Work Phone Number:	Patient Occupation:	Employment Status: ☐ FT ☐ PT ☐ Retired

Worker's Compensation * AutoCarrier *** Attorney Information (LOP NEEDED)**

Worker's Comp, Auto Carrier or Attorney Name:	Worker's Comp, Auto Carrier or Attorney Billing Address:	
Claim Number:	Contact Name & Phone Number:	**Date of Injury: _____ State _____**

Financially Responsible Party/Guarantor-Other Than Patient Or Insurance

Full Name (First, MI, Last, Suffix):			Relationship to Patient:
Address:	City:	State:	Zip Code:
Primary Phone: ☐ Home ☐ Cell	**Privacy Policy Exclusion:** Is there anyone we are **NOT ALLOWED** to speak to about your care or account?		

By signing below I acknowledge that all the above information is true and accurate. If at any time any of this information changes, I am aware that I must inform the facility immediately.

I, acknowledge that the above information is correct **Patient/Guardian_____Date_____**	**Have you had any prior Therapy this year (PT/OT/ST or Chiropractic)?** ☐ **Yes** ☐ **No**

Facility: Comprehensive Physical Therapy Solutions, LLC

MEDICAL HISTORY Pg 1
PT OT

Patient Name_____ Subscriber ID #_____ Primary Language_____

DOB: _____

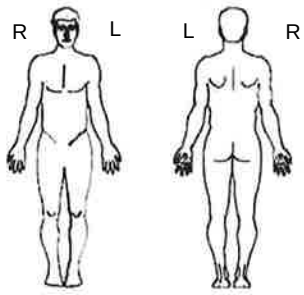
Describe Your Current Problem and How It Began_____

_____

_____

Onset date/Surgery date_____

Indicate below where you have pain or other symptoms



Is this? ☐ Work Related ☐ Auto Related ☐ N/A

How often are your symptoms present?

☐ Constantly (76-100% of the day) ☐ Occasionally (26-50% of the day)
☐ Frequently (51-75% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your pain:

☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling

How is your condition changing?

☐ Getting Better ☐ Not Changing ☐ Getting Worse

Current complaint (how you feel today):

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

Check if you have difficulty: ☐ Seeing ☐ Hearing ☐ Talking ☐ Memory ☐ Swallowing

What is your most effective learning method: ☐ Seeing ☐ Hearing ☐ Talking ☐ Doing ☐ Pictures

In general would you say your overall health right now is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Have you had x-rays, MRI, CT Scan for your area(s) of complaint? ☐ Yes ☐ No

Date(s) taken_____ **What areas were taken?**_____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Cardiac Condition
☐ Stroke (Date)_____
☐ Dizziness/Fainting
☐ Cancer/Tumor (Explain)_____
_____
☐ Osteoporosis
☐ Other Health Problems (Explain)_____
_____

☐ Numbness /Weakness (Location)_____
☐ Urinary Problems
☐ Currently Pregnant, # Weeks_____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Surgeries_____
_____ more space see page 2
☐ Tobacco Use - Type_____
Frequency_____/Day
☐ Current Medications see page 2
_____

Who have you seen for your condition before today? ☐ No One

☐ Medical Doctor ☐ Massage Therapist ☐ Chiropractor ☐ Other_____
☐ Physical Therapist ☐ Acupuncturist ☐ Occupational Therapist ☐ Speech Therapist ☐ Athletic Trainer

What treatment did you receive and when?_____

What is your occupation?_____

Medical History Page 2

Last name: _____ First Name: _____ D.O.B. _____

Allergies: Are you latex sensitive? ☐yes ☐ no List any other allergies:_____
_____

Do you have a pace maker or medical implant? ☐ yes ☐ no

SURGERIES (cont from page 1):

Include Date Reason for Surgeries:

1. _____ _____ 4._____ _____
2. _____ _____ 5. _____ _____
3. _____ _____ 6. _____ _____

MEDICATIONS

Please list **ALL** medications (INCLUDING prescription, over-the-counter, herbals, vitamin/mineral/dietary (nutritional) supplements, injections, and/or skin patches) that you are **currently** taking. For each medication, please list the name, dosage, frequency, and route (by mouth, inhaler, intravenously, topically, etc). You may attach a copy of your own list of medications if available.

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
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Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

I certify to the best of my knowledge, the above information is complete and accurate. I agree to notify this provider/practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that this provider/practitioner may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to this provider/practitioner to contact my physician, if necessary.

Patient/Responsible Party Signature_____**Date**_____

Reviewed with Patient: _____ **Date:** _____