# Active Physical Therapy Patient Information

| **PATIENT INFORMATION** **(Please give insurance card and driver's license to receptionist)** | | | **Today's Date: / /** |
|---|---|---|---|
| First Name: | Last Name: | Middle Initial: | |
| Preferred Name/Nickname: | | | |
| Address: | City: | State: | Zip: |
| Birth date: / / | Age: | ❑Male ❑Female | S.S. #: - - |
| **Home** Phone: ( ) - | **Cell** Phone: ( ) - | | Marital Status: |
| If minor, names of parents: | | | |
| **Why did you choose Active?** | | | |
| **INSURANCE INFORMATION** | | | **(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)** |
| Subscriber's Name (If different): | | | Birth date : / / |
| **IN CASE OF EMERGENCY** | | | |
| Name of Local Friend or Relative: | | | |
| Relationship to Patient: | Home Phone: ( ) - | Work Phone: ( ) - | |

## PAST MEDICAL HISTORY

| Blood pressure | Yes | No |
|---|---|---|
| Hypertension | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ |
| Normal Blood Pressure | ☐ | ☐ |

| Heart Disease | Yes | No |
|---|---|---|
| Heart Attack | ☐ | ☐ |
| Atherosclerotic Disease | ☐ | ☐ |
| Rheumatic Heart Disease | ☐ | ☐ |
| Heart Murmur | ☐ | ☐ |
| Pacemaker/Defibrillator | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Congestive Heart Failure | ☐ | ☐ |

| Lungs | Yes | No |
|---|---|---|
| Asthma | ☐ | ☐ |
| Emphysema/COPD | ☐ | ☐ |
| Shortness of Breath | ☐ | ☐ |

| Other Conditions | Yes | No |
|---|---|---|
| Muscular Dystrophy | ☐ | ☐ |
| Rheumatoid Arthritis | ☐ | ☐ |
| Multiple Sclerosis | ☐ | ☐ |
| Epilepsy/Seizures | ☐ | ☐ |
| Gout | ☐ | ☐ |
| Fibromyalgia | ☐ | ☐ |
| Type I Diabetes | ☐ | ☐ |
| Type II Diabetes | ☐ | ☐ |
| Hearing Loss | ☐ | ☐ |
| Poor Eyesight | ☐ | ☐ |
| Fainting | ☐ | ☐ |
| Polio | ☐ | ☐ |
| Cancer (current or past) | ☐ | ☐ |
| Autoimmune Condition | ☐ | ☐ |
| Blood Clots | ☐ | ☐ |
| Anxiety | ☐ | ☐ |
| Depression | ☐ | ☐ |

Other Medical Conditions:_____

_____

_____

_____

_____

_____

| Exercise | Work Activity | Stress Level | Habits |
|---|---|---|---|
| □ None | □ Sitting | □ Low | □ Smoking Packs/Day _____ |
| □ 1-2x/wk | □ Standing | □ Medium | □ Alcohol Drinks/Wk _____ |
| □ 3-4x/wk | □ Light Labor | □ High | □ Coffee/Soda Cups/Wk _____ |
| □ 5+ x/wk | □ Heavy Labor | | |

What types of exercises do you perform? _____
What things cause stress in your life? _____

Are you taking any seizure medications? □YES □NO If yes, list name: _____
Are you taking any Medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy? □YES □NO If Yes, List Name: _____
List all medications you are currently taking (or please provide a list to copy):

_____

_____

List all surgeries including dates:
Surgery:_____ Date: _____
Surgery:_____ Date: _____
Surgery:_____ Date: _____
Surgery:_____ Date: _____
Are you pregnant? □YES □NO If so, what week? _____
Have you had any injuries related to work? □YES □NO If Yes, List body part and date: _____
_____
Have you had any auto accidents? □YES □NO If Yes, List body part and date: _____
_____
Have you had physical therapy before? □YES □NO Where? _____

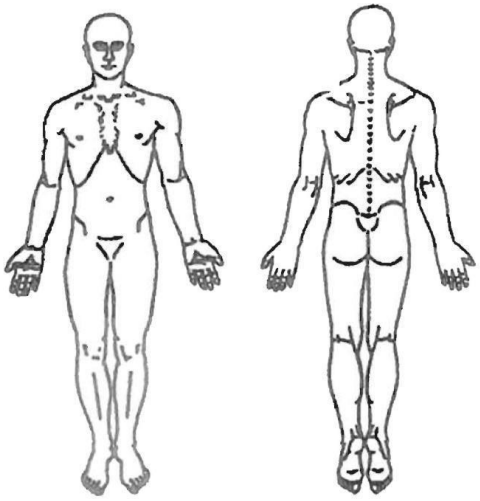
**Please circle the number that you feel correlates with the following statements.**

| | Strongly disagree | Disagree | Agree | Strongly Agree |
|---|---|---|---|---|
| I'm afraid that I might injure myself if I exercise. | 1 | 2 | 3 | 4 |
| Pain always means I have injured my body. | 1 | 2 | 3 | 4 |
| People aren't/haven't taken my medical condition seriously enough. | 1 | 2 | 3 | 4 |

## Pain and Symptom Status Report

Using the symbols below, please draw at the type of pain you are having over the affected area.

- **M** (Ache)
- − (Burning)
- **O** (Numbness)
- Δ (Pins & Needles)
- **//** (Stabbing)
- **XX** (Other)_____



## Chief Complaint and Visual Analog Scale

Date of Injury: _____
My chief complaint is: _____

**Please indicate below your <u>CURRENT</u> level of pain** (0 = No Pain, 10 = Unbearable Pain)

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|

**Please indicate below your <u>LOWEST</u> level of pain** (0 = No Pain, 10 = Unbearable Pain)

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|

**Please indicate below your <u>WORST</u> level of pain** (0 = No Pain, 10 = Unbearable Pain)

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|

Describe your injury/condition and when/how it occurred:

_____
_____

What are your goals for therapy?

_____
_____

## Policy Receipt, Acknowledgement and Agreement

*<u>Please Read the attached laminated policies. Initial here next to each line, then print, sign, and date below.</u>*

_____ I have read and agree to Active Physical Therapy's Financial Policy.

_____ I have read and agree to Active Physical Therapy's Notice of Privacy Practices.

_____ I have read and agree to Active Physical Therapy's Cancellation Policy.

_____ I have read and agree to Active Physical Therapy's Safety Policy.

_____ I have been given the opportunity to read, fully understand and ask questions regarding the above policies. I also am aware that I can request a copy of these policies at any time.

If there is someone whom you would like us to release your information to, please fill in their name below.

_____ _____ _____

_____ _____ _____

(Name) (Relationship) (Phone)

**PATIENT NAME (Print):_____**

**SIGNATURE:_____ DATE:_____**
**(Patient, Parent, Guardian, Personal Representative**