Active Physical Therapy Patient Information

PATIENT INFORMATION **(Please hand insurance card and driver's license to reception)**			**Today's Date: / /**
First Name:	Last Name:	Middle Initial:	Marital Status: M S D W
Birth Date: / /	Age:	☐ Male ☐ Female	S.S. # - -
Address:	City:	State:	Zip Code:
Home Phone: ( ) -	Cell Phone: ( ) -	Email Address:	
How did you hear about us: Dr Referral Family Friend Website Street Sign Previous patient Google Other			
AUTO OR WORK INJURY CLAIM			
Insurance Name: ☐ Auto:		☐ Labor and Industries:	
Adjuster/Claim Manager:		Phone: ( ) -	
Address:	City:	State:	Zip Code:
Claim #:	Accident Date: / /	Cause:	
EMERGENCY CONTACT INFORMATION			
Name:		Phone: ( ) -	
Relationship to Patient:			

PAST MEDICAL HISTORY (Place a ✓ under Y or N)

BLOOD PRESSURE	**Y**	**N**	**JOINT CONDITION**	**Y**	**N**
Hypertension			Upper Extremity		
Low Blood Pressure			Lower Extremity		
Normal Blood Pressure			Neck		
HEART DISEASE	**Y**	**N**	Back		
Heart Attack			**OTHER CONDITIONS**	**Y**	**N**
Atherosclerosis Disease			Muscular Dystrophy		
Myocardial Infarction			Rheumatoid Arthritis		
Stroke			Multiple Sclerosis		
Heart Murmur			Epilepsy/Seizures		
Congestive Heart Failure			Gout		
Pacemaker/Defibrillator			Fibromyalgia		
MUSCLE CONDITION	**Y**	**N**	Diabetes Type: **I II**		
Carpal Tunnel R/L			Hearing Loss		
Tennis Elbow R/L			Poor Eyesight		
Back/Neck Problems			Fainting		
Limited Limb Movement			Cancer (current or past)		
LUNGS	**Y**	**N**	Autoimmune Disease		
Asthma			Blood Clots		
Emphysema/COPD			Depression		
Shortness of Breath			Anxiety		

Please list Any Other Medical Conditions Not Listed Above: _____

_____

Please List All Surgeries and Dates: _____

_____

_____

_____

EXERCISE		WORK ACTIVITY		STRESS LEVEL		HABITS		
None	⬭	Sitting	⬭	Low	⬭	Smoking	⬭	Packs per Day __
1-2 x per Week	⬭	Standing	⬭	Medium	⬭	Alcohol	⬭	Drinks per Week
3-4 x per Week	⬭	Light Labor	⬭	High	⬭	Coffee/Soda	⬭	Cups per Week
5+ x per Week	⬭	Heavy Labor	⬭					

What types of exercise 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 provide a list):

_____ _____

_____ _____

_____ _____

_____ _____

Are you pregnant? Yes ⬭ No ⬭ If yes, how many weeks? _____

Have you had any injuries related to work or auto Accident? ⬭ Yes ⬭ No If yes, list body part and date of injury.

_____

_____

Have you had physical therapy before? ⬭ Yes ⬭ No If yes, Where? _____

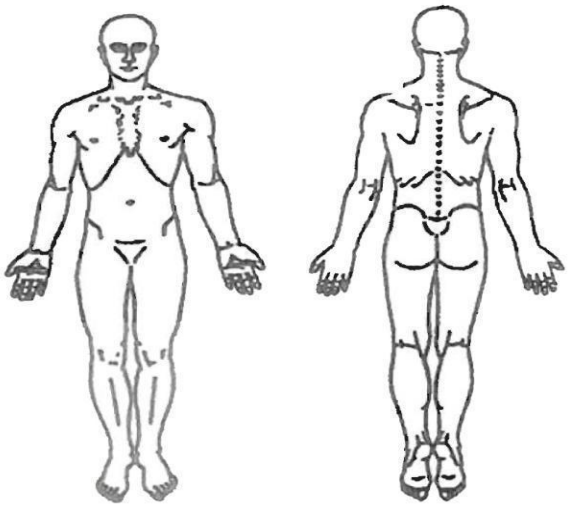
Please circle the number that you feel correlates with the following statements.

	Strongly disagree	Disagree	Agree	Strongly Agree
I'm afraid that I might injury myself if I exercise.	1	2	3	4
Pain always means that 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 CURRENT level of pain (0 = No Pain, 10 = Unbearable Pain)

0	1	2	3	4	5	6	7	8	9	10

Please indicate below you LOWEST level of pain (0 = No Pain, 10 = Unbearable Pain)

0	1	2	3	4	5	6	7	8	9	10

Please indicate below your WORST 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? _____

_____

RELEASE OF INFORMATION (Indicate whom you would like us to release your information to)		
Name:	Relationship:	Phone: ( ) -
Name:	Relationship:	Phone: ( ) -

Medical Insurance Information	☐ **No Medical Insurance**

POLICY RECEPT, ACKNOWLEDGEMENT AND AGREEMENT

*Please read the attached laminated policies, **Initial** here next to each line:*

____ 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 am also aware that I can request a copy of these policies at any time.

I authorize my insurance benefits be paid directly to ***Marquette Rehabilitation & Sport Medicine Center***. I understand that I am financially responsible for my balance. I also authorize the release of any information required to process my claims.

Patient Name (Print) _____

Signature: _____ **Date:** _____

(Signature of Patient, Parent, Guardian, Personal Representative)