

ORTHOSPORT PHYSICAL THERAPY PATIENT INFORMATION FORM

Patient's Personal Information

Mr. Mrs. Ms. : _____
(Please Circle One)

_____ **First Name** _____ **M.I.** _____ **Last Name**

Sex: F M _____
(Please Circle One)

Social Security# _____ DOB _____
MM / DD / YY

Address: _____
_____ **Street** _____ **City** _____ **Zip**

Home Phone# _____ Cell Phone# _____

Driver's License# _____ Driver's License State: _____

Email Address: _____ Sign-up for Email appointment reminder

Employer Information

Employer: _____ Work Phone# _____
(Parent's, if child is minor)

Address: _____
_____ **Street** _____ **City** _____ **Zip**

Emergency Contact

Name: _____ Relation: _____ Phone# _____

Name: _____ Relation: _____ Phone# _____

Policy Holder Information

Check here if you are the policy holder & leave this section blank Relation to Policy Holder: _____

To your knowledge, how many therapy visits (physical, speach and occupational) have been used this year? _____

To your knowledge, how many chiropractic visits have been used this year? _____

Policy Holder Name: _____
_____ **First Name** _____ **M.I.** _____ **Last Name**

Policy Holder Social Security# _____ Policy Holder DOB _____

Policy Holder Employer _____ Employer Phone# _____

Policy Holder Employer Address: _____
_____ **Street** _____ **City** _____ **Zip**

Referring Physician Information

Referring Physician: _____
_____ **First Name** _____ **M.I.** _____ **Last Name**

Address: _____
_____ **Street** _____ **City** _____ **Zip**

Physician's Phone# _____

ORTHOSPORT PHYSICAL THERAPY - SUBJECTIVE MEDICAL HISTORY

PATIENT NAME: _____

How did you hear about us?

Primary Complaint(s):

Date of Onset/Surgery:

Are your symptoms due to:

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Sports | <input type="checkbox"/> Work Injury |
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Chronic | <input type="checkbox"/> Overuse |
| <input type="checkbox"/> Motor Vehicle Accident | |

Since onset, Are your symptoms: (Circle)

SAME BETTER WORSE

What are your goals/reason for treatment

Since onset, have you had:

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> MRI | <input type="checkbox"/> X-Ray |
| <input type="checkbox"/> Injections | <input type="checkbox"/> CT Scan |
| <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Nerve Conduction |
| <input type="checkbox"/> Bone Scan | <input type="checkbox"/> Blood Tests |
| <input type="checkbox"/> Other _____ | |

Results from above tests:

Do you currently smoke or use tobacco? Y N

How many packs? _____

Are you or could you be pregnant? Y N

Have you had prior episodes of the same symptoms?

Y N

How many / When? _____

Which treatment have you, or are you currently receiving for THIS condition?

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> Injections |
| <input type="checkbox"/> Bed Rest | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Chiropractor |
| <input type="checkbox"/> Nerve Blocks | <input type="checkbox"/> Other _____ |

When? _____

What is your occupations? _____

What activities does your job require / how many hours at each?

- | | |
|--|---|
| <input type="checkbox"/> Sitting _____ | <input type="checkbox"/> Computer _____ |
| <input type="checkbox"/> Standing _____ | <input type="checkbox"/> Walking _____ |
| <input type="checkbox"/> Lifting : How many lbs? _____ | |
| <input type="checkbox"/> From Floor | <input type="checkbox"/> Overhead |
| <input type="checkbox"/> Orther _____ | |

Which of thoses activities are you having trouble with? _____

What was your previous functional level?

Limited with functional activities: Y N

Limited with work activities: Y N

Limited with recreational activities: Y N

Other: _____

ORTHOSPORT PHYSICAL THERAPY - SUBJECTIVE MEDICAL HISTORY

PATIENT NAME: _____

Please check the activities that increase your symptoms:

- | | | |
|--|---|--|
| <input type="checkbox"/> Walking: with device | <input type="checkbox"/> On/ Off: Shoes/ Socks | <input type="checkbox"/> Reaching: under cabinet |
| <input type="checkbox"/> Walking: uneven terrain | <input type="checkbox"/> Belt/ Bra | <input type="checkbox"/> Reaching: overhead |
| <input type="checkbox"/> Walking: indoors | <input type="checkbox"/> Driving | <input type="checkbox"/> Running |
| <input type="checkbox"/> Walking: outdoors | <input type="checkbox"/> Eating/ Utensils | <input type="checkbox"/> Sewing |
| <input type="checkbox"/> Balance/ Safety | <input type="checkbox"/> Gripping _____ | <input type="checkbox"/> Sitting _____ |
| <input type="checkbox"/> Sports | <input type="checkbox"/> Grocery Shopping | <input type="checkbox"/> Squatting |
| <input type="checkbox"/> Bathing/ Showering | <input type="checkbox"/> House Hold Chores | <input type="checkbox"/> Stairs: up / down |
| <input type="checkbox"/> Bed Mobility | <input type="checkbox"/> Jumping | <input type="checkbox"/> Standing _____ |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Kicking | <input type="checkbox"/> Transfers: sit ↔stand |
| <input type="checkbox"/> Care Giving: infants/others | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Transfers: sit ↔lying |
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Ladders | <input type="checkbox"/> Typing |
| <input type="checkbox"/> Carrying: Groceries | <input type="checkbox"/> Lifting: from floor | <input type="checkbox"/> Writing |
| <input type="checkbox"/> Carrying: other objects | <input type="checkbox"/> Lifting: overhead | <input type="checkbox"/> Yard Work |
| <input type="checkbox"/> Carrying: laundry | <input type="checkbox"/> Load/Unload Dishwasher | <input type="checkbox"/> Pushing _____ |
| <input type="checkbox"/> Cleaning | <input type="checkbox"/> Curbs/Ramps | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cooking | <input type="checkbox"/> Buttons | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Crawling | <input type="checkbox"/> Opening Jars | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Lying on stomach/ back | <input type="checkbox"/> Open/Close Doors | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Lying on Right /left | <input type="checkbox"/> Pulling _____ | <input type="checkbox"/> Other: _____ |

Please Check the following activities that RELIEVE

your symptoms:

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> Rest | <input type="checkbox"/> Heat | <input type="checkbox"/> Ice |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Walking | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Lying Down | <input type="checkbox"/> Modify Activity | <input type="checkbox"/> Stop Activity |
| <input type="checkbox"/> Medication | | |
| <input type="checkbox"/> Other _____ | | |

Please describe your pain?

- | | | |
|--------------------------------------|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Dull | <input type="checkbox"/> Sharp | <input type="checkbox"/> Achy |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Steady | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Radiating | <input type="checkbox"/> Pins/Needles | |
| <input type="checkbox"/> Other _____ | | |

Are your symptoms worse in the:

- | | | |
|-----------------------------|-----------------------------|-------------------------------|
| <input type="checkbox"/> AM | <input type="checkbox"/> PM | <input type="checkbox"/> Same |
|-----------------------------|-----------------------------|-------------------------------|

What is the Frequency of your Pain?

- | | | |
|---|--------------------------------|--|
| <input type="checkbox"/> Constant | <input type="checkbox"/> Daily | <input type="checkbox"/> Less than daily |
| <input type="checkbox"/> Less than weekly | <input type="checkbox"/> _____ | |

What activities do you wish to return to?

Have you ever received treatment for any of the following?:

- | | | |
|---------------------------------------|-------------------------------------|---------------------------------|
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Back | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> Foot/Ankle | <input type="checkbox"/> Pelvis |
| <input type="checkbox"/> Hand | <input type="checkbox"/> Head | <input type="checkbox"/> Hip |
| <input type="checkbox"/> Other: _____ | | |

If Yes, Please describe:

ORTHOSPORT PHYSICAL THERAPY - SUBJECTIVE MEDICAL HISTORY

PATIENT NAME: _____

Would you like a complimentary consultation scheduled?

Y N

Any Previous Surgeries:

Have you ever experienced any of the following, since the onset of your symptoms?

- | | |
|---|--|
| <input type="checkbox"/> Recent Fever / Chills | <input type="checkbox"/> Nausea / Vomiting |
| <input type="checkbox"/> Urgency/Straining with Urination | <input type="checkbox"/> Dizziness / Vertigo |
| <input type="checkbox"/> Unexplained Weight Loss | <input type="checkbox"/> Incontinence |

Please check all of the following conditions regarding your medical history:

- | | |
|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Astma |
| <input type="checkbox"/> Blood Pressure (↑ / ↓) | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Glcoma |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Kidney Failure |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Hot / Cold Sensitivity | |
| <input type="checkbox"/> Other: _____ | |

Please List All Mediciations you are currently taking:

1 _____

2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____
10 _____

Please Rate Your Pain Scale:

Current: _____ Best: _____ Worse: _____

- 0 No Pain
- 1 Mild, you are aware, but it doesn't bother you
- 2 Mild; more aware, begins to bother you
- 3 Moderate; tolerate without medication
- 4 Moderate; tolerate with medication
- 5 Severe; affects life
- 6 Severe; cannot participate in activities
- 7 Very Severe; cannot participate in daily activities
- 8 Intensely Severe; cannot leave the house
- 9 Extremely Severe; cannot get out of bed
- 10 Most Severe; contemplate going to the ER

Please indicate with an 'X' where your pain is.

