Spectrum Physical Therapy & Chiropractic

CONFIDENTIAL PATIENT INFORMATION

In order to serve you properly, we need the following information *filled out COMPLETELY* please. Thank you.

1. **NAME**:

_____

a. Last

_____

b. First c. MI d. Jr/Sr

2. **Street Address**: _____

_____

City *State* *Zip*

3. **Date of Birth**: _____ **AGE:** _____

4. **SEX**: ☐Male ☐Female **Are You**: ☐Right-handed ☐Left-Handed

5. **MARITAL STATUS**: ☐Married ☐Single ☐Widow ☐Divorced

6. **SOCIAL SECURITY #**_____

7. **Type of Insurance**: ☐Insurer: _____
☐ Workers Comp ☐Medicare ☐Self-pay

8. **Race**
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

9. **Ethnicity**
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

10. **Language**
- ☐ English understood
- ☐ Interpreter needed
- ☐ Language spoken most often

11. **Education**:
Highest grade completed (circle one) 1 2 3 4 5 6 7 8 9 10 11 12
- ☐ Some college / technical school
- ☐ College graduate
- ☐ Graduate school / advanced degree

SOCIAL HISTORY

12. **Cultural / Religious**: Any customs or religious beliefs or wishes that might affect care?

_____

13. With whom do you live:
- ☐ Alone
- ☐ Spouse only
- ☐ Spouse and other(s)
- ☐ Child (not spouse)
- ☐ Other relative(s) (Not spouse or children)
- ☐ Group setting
- ☐ Personal care attendant
- ☐ Other: _____

14. Have you completed an advance directive? Yes☐ No☐

15. Who referred you to the physical therapist?

_____

16. Employment/Work (Job/School/Play)
- ☐ Work Full Time outside of home
- ☐ Work Part Time outside of home
- ☐ Work Full time from home
- ☐ Work Part time from home
- ☐ Homemaker ☐Student ☐Retired ☐Unemployed

Occupation: _____

LIVING ENVIRONMENT

17. **Does your home have:**
- ☐ Stairs, no railing
- ☐ Stairs, railing
- ☐ Ramps
- ☐ Elevator
- ☐ Uneven terrain
- ☐ Assistive devices
- ☐ Any obstacles?

18. **Do you use:**
- ☐ Cane
- ☐ Walker or rollator
- ☐ Manual wheelchair
- ☐ Motorized wheelchair
- ☐ Glasses, hearing aids
- ☐ Other: _____

_____

19. **Where do you live**:
- ☐ Private home
- ☐ Private apartment
- ☐ Rented room
- ☐ Board and care / assisted living/ group home
- ☐ Homeless (with or without shelter)
- ☐ Long-term care facility (nursing home)
- ☐ Hospice
- ☐ Other _____

20. **GENERAL HEALTH STATUS**

Please rate your health:
☐Excellent ☐Good ☐Fair ☐Poor

Have you had any major life changes during the past year? (New baby, job change, death in family) Yes☐ No☐

21. **SOCIAL/HEALTH HABITS**

Do you currently smoke tobacco?
- ☐ Yes # of packs per day _____
- ☐ No

Have you smoked in the past?
- ☐ Yes Year quit _____
- ☐ No

How many days per week do you drink beer, wine, or other alcoholic beverages, on average? _____

If one beer, one glass of wine, or one cocktail equals one drink, how many drinks do you have on an average day? _____

Exercise:

Do you exercise beyond normal daily activities and chores?

☐ Yes – Describe the exercise: _____

How many days per week? _____

For how many minutes? _____

☐ No

22. FAMILY HISTORY (Indicate whether mother, father, brother/sister, aunt/uncle, or grandmother/grandfather and age of onset if known)

Heart disease: _____
Hypertension: _____
Stroke: _____
Diabetes: _____
Cancer: _____
Psychological: _____
Arthritis: _____
Osteoporosis: _____
Other: _____

23. MEDICAL/SURGICAL HISTORY:

Please check if you have ever had:

☐ Arthritis
☐ Broken Bones/fractures
☐ Osteoporosis
☐ Blood disorders
☐ Circulation/vascular problems
☐ Heart problems
☐ High blood pressure
☐ Lung problems
☐ Stroke
☐ Diabetes/High blood sugar
☐ Low blood sugar/Hypoglycemia
☐ Head injury
☐ Ulcers/stomach problems
☐ Depression
☐ Multiple sclerosis
☐ Muscular dystrophy
☐ Parkinson Disease
☐ Seizures/epilepsy
☐ Allergies
☐ Developmental or growth problems
☐ Thyroid Problems
☐ Cancer
☐ Infectious disease
☐ Kidney problems
☐ Repeated infection
☐ Skin diseases
☐ Other _____

Within the past year, have you had any of the following symptoms? Check ALL that apply.

☐ Chest pain
☐ Heart palpitations
☐ Cough
☐ Hoarseness
☐ Shortness of breath
☐ Dizziness/blackouts
☐ Coordination problems
☐ Weakness in arms/legs
☐ Loss of balance
☐ Difficulty walking
☐ Joint pain/swelling
☐ Pain at night
☐ Difficulty sleeping
☐ Loss of appetite
☐ Nausea/vomiting
☐ Difficulty swallowing
☐ Bowel problems
☐ Weight loss/gain
☐ Urinary problems
☐ Fever/chills/sweats
☐ Headaches
☐ Hearing problems
☐ Vision problems
☐ Other: _____

Have you ever had surgery? ☐ Yes ☐No
If yes, please describe and include dates:

_____
_____
_____

For men only: Have you been diagnosed with prostate disease? ☐ Yes ☐ No

For women only: Have you been diagnosed with?

Pelvic inflammatory disease?	☐ Yes	☐ No
Endometriosis?	☐ Yes	☐ No
Trouble with your period?	☐ Yes	☐ No
Complicated pregnancies or deliveries?	☐ Yes	☐No
Pregnant, or think you might be?	☐ Yes	☐ No
Other gynecological or obstetrical difficulties?	☐ Yes	☐ No

If yes, please describe _____
_____

24. CURRENT CONDITION/CHIEF COMPLAINTS

-Describe the problem(s) for which you seek physical therapy:

_____

_____

-When did the problem(s) begin? _____

-What happened?

_____

_____

-Have you ever had this problem before? ☐Yes ☐No

If YES:

-What did you do for the problem? _____

-Did the problem get better? ☐ Yes ☐ No

-How long did the problem last? _____

-How are you taking care of the problem now? _____

What makes the problem better? _____

What makes the problem worse? _____

What are your goals for physical therapy? _____

Are you seeing anyone else for the problem? Check all that apply.

☐ Acupuncturist
☐ Cardiologist
☐ Chiropractor
☐ Dentist
☐ Family practitioner
☐ Internist
☐ Massage therapist
☐ Neurologist
☐ Obstetrician/gynecologist
☐ Occupational therapist
☐ Orthopedist
☐ Osteopath
☐Pediatrician
☐ Podiatrist
☐ Primary care physician
☐ Rheumatologist
☐ Other _____

JOB INJURY INFORMATION:

Date: _____ Time: _____ Location: _____

Description of accident: _____

_____

Workmans' Compensation Case # _____

Insurance Company(Carrier): _____ Address: _____

Insurance Company/Carrier Case #: _____

Employer's Name: _____ Address: _____

Hospitalized? ☐YES ☐ NO Name of Hospital: _____ X-Rays Taken? ☐YES ☐ NO

Other Doctors seen: _____

Are you working now? ☐YES ☐NO - ☐ FULL ☐ PART-TIME

Time lost from work (if any): From _____ to _____

ACCIDENT INFORMATION:

Date: _____ Time: _____ Location: _____

How did accident occur? ☐ Auto Collision ☐ Other (explain) _____

If auto accident, were you ☐ Driver ☐ Passenger ☐ Pedestrian

If auto collision, were you struck from ☐ Behind ☐Front ☐ Right Side ☐ Left Side ☐ Auto was Parked

Did your car strike the other(s) involved? ☐YES ☐NO OR Did the other car strike your vehicle? ☐YES ☐NO ☐ Undetermined

As a result of the accident, were traffic citations issued to you? ☐YES ☐NO To the driver of the other vehicle? ☐YES ☐NO

List the extent of the injuries as you know them:

_____

Did you require post-accident hospitalization? ☐YES ☐NO If so, how long: _____

Check symptoms you have noticed since the accident:

☐ Headache	☐ Dizziness	☐ Light Bothers Eyes	☐ Diarrhea
☐ Neck Pain	☐ Head Seems Too Heavy	☐ Loss of Memory	☐ Feet Cold
☐ Neck Stiff	☐ Pins and Needles in Arms	☐ Ears Ring	☐ Hands Cold
☐ Sleeping Problems	☐ Pins and Needles in Legs	☐ Face Flushed	☐ Stomach Upset
☐ Back Pain	☐ Numbness in Fingers	☐ Buzzing in Ears	☐ Constipation
☐ Nervousness	☐ Numbness in Toes	☐ Loss of Balance	☐ Cold Sweats
☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever
☐ Irritability	☐ Fatigue	☐ Loss of Smell	☐_____
☐ Chest Pain	☐ Depression	☐ Loss of Taste	☐_____

Symptoms other than above: _____

Have you lost any days of work? ☐YES ☐NO Dates: _____

Insurance Companies involved: _____

Your Insurance Company: _____ Your Claim Number: _____

Company of person responsible for injuries? _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? ☐YES ☐NO

Do you have an attorney that has advised you in this case? ☐YES ☐NO Attorney Name: _____

25. FUNCTIONAL STATUS / ACTIVITY LEVEL (Check all that apply)

☐ Difficulty with locomotion/movement:
- ☐ bed mobility
- ☐ transfers such as moving from bed to chair
- ☐ gait (walking)
  - ☐ on level surface ☐ on ramps
  - ☐ on stairs ☐ on uneven terrain

☐ Difficulty with self-care (such as bathing, dressing, eating, toileting?

☐ Difficulty with home management (such as household chores, shopping, driving/transportation, care of dependents)

☐ Difficulty with community and work activities/integration?

26. MEDICATIONS

Do you take any prescription medications? ☐ Yes ☐ No
If yes, please list: _____

_____

Do you take any non-prescription medications? (Check all that apply)

☐ Advil / Aleve
☐ Antacids
☐ Ibuprofen/Naproxen
☐ Antihistamines
☐ Aspirin
☐ Decongestants
☐ Herbal supplements
☐ Tylenol
☐ Other: _____
_____

Have you taken any medication previously for the condition for which you are seeing the physical therapist? ☐ Yes ☐No

27. OTHER CLINICAL TESTS – Within the past year, have you had any of the following tests? (Check all that apply)

☐ Angiogram
☐ Arthroscopy
☐ Biopsy
☐ Blood tests
☐ Bone scan
☐ Bronchoscopy
☐ CT Scan
☐ Doppler ultrasound
☐ Echocardiogram
☐ EEG (electroencephalogram)
☐ EKG (electrocardiogram)
☐ EMG (electromyogram)
☐ Mammogram
☐ MRI
☐ Myelogram
☐ NCV (nerve conduction study)
☐ Pap smear
☐ Pulmonary function test
☐ Spinal tap
☐ Stool tests
☐ Stress test
☐ Urine test
☐ X-rays
☐ Other: _____

PLEASE NOTE: If this is a Worker's Compensation or a No Fault injury, please fill out all of the information on Page 4.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that I authorize payment directly to this office which will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I authorize the release of any medical or other information pertinent to my treatment and necessary to process any insurance claims.

Patient's Signature: _____ Date: _____

Guardian / Parent Permission to treat minor: _____ Date: _____