SPORT & SPINE PHYSICAL THERAPY INTAKE FORM

(PLEASE PRINT AND COMPLETE IN FULL)

PATIENT NAME_____ DOB_____

ADDRESS_____

(STREET) (CITY) (STATE) (ZIP)

PHONE (MOBILE) _____ (HOME) _____ (WORK) _____

EMERGENCY CONTACT _____PHONE#_____

EMAIL _____ MONTHLY NEWS LTR (YES) OR (NO)

HOW DID YOUR HEAR ABOUT SPORT & SPINE? _____ EMPLOYER NAME_____

EMPLOYER ADDRESS_____

(STREET) (CITY) (STATE) (ZIP)

IF INJURY IS WORK RELATED, PLEASE FILL OUT THIS SECTION.

CONTACT AT EMPLOYMENT TO VERIFY INJURY_____PHONE_____EXT_____

DATE OF INJURY_____ BRIEF DESCRIPTION OF INJURY _____

_____ CLAIM #_____

WORKMANS COMP CARRIER_____PHONE #_____EXT_____

IF THE INJURY IS RELATED TO AN AUTO ACCIDENT/PERSONAL INJURY, PLEASE FILL OUT THIS SECTION.

DATE OF INJURY_____ BRIEF DESCRIPTION OF INJURY_____

_____LAWYER'S NAME_____

PHONE #_____MEDPAY INSURANCE_____PHONE #_____

MEDPAY INSURANCE HOLDER_____POLICY #_____

(BY NOT FILLING OUT THE WORK RELATED SECTION OR THE AUTO ACCIDENT/PERSONAL INJURY SECTION, I AM STATING TO THIS OFFICE THAT MY INJURY IS IN NO WAY RELATED TO MY EMPLOYMENT OR IS NOT THE RESULT OF AN AUTO ACCIDENT/PERSONAL INJURY)

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE	ID#	SUBSCRIBER'S NAME	DOB	RELATION TO PATIENT

SECONDARY INSURANCE	ID#	SUBSCRIBER'S NAME	DOB	RELATION TO PATIENT

BY SIGNING THIS FORM, I AM CONFIRMING THAT ALL INFORMATION ON THIS FORM IS ACCURATE AND COMPLETE. I ALSO, UNDERSTAND THAT IF THE PATIENT IS UNDER THE AGE OF 18, I AM SIGNING AS THEIR GUARDIAN/LEGAL GUARDIAN.

SIGNATURE:_____**DATE:**_____

SPORT AND SPINE PHYSICAL THERAPY
MEDICAL SCREENING FORM

PATIENT NAME: _____ DATE: _____

CIRCLE YES OR NO

HAVE YOU OR ANY IMMEDIATE FAMILY MEMBER EVER BEEN TOLD YOU OR THEY HAVE OR HAVE HAD A/AN:

	SELF		FAMILY	
CANCER	YES	NO	YES	NO
DIABETES	YES	NO	YES	NO
HIGH BLOOD PRESSURE	YES	NO	YES	NO
HEART DISEASE	YES	NO	YES	NO
ANGINA/CHEST PAIN	YES	NO	YES	NO
STROKE	YES	NO	YES	NO
HEART MURMUR	YES	NO	YES	NO
ABNORMAL HEART RATE	YES	NO	YES	NO
OSTEOPOROSIS	YES	NO	YES	NO
OSTEOARTHRITIS	YES	NO	YES	NO
REHUMATOID ARTHRITIS	YES	NO	YES	NO

IN THE PAST THREE MONTHS HAVE YOU HAD OR DO YOU EXPERIENCE:

A CHANGE IN YOUR HEALTH	YES	NO
NAUSEA / VOMITING	YES	NO
FEVER/CHILLS/NIGHT SWEATS	YES	NO
UNEXPLAINED WEIGHT CHANGE	YES	NO
NUMBNESS OR TINGLING	YES	NO
CHANGE IN APPETITE	YES	NO
DIFFICULTY SWALLOWING	YES	NO
CHANGES IN BLADDER/ BOWEL FUNCTION	YES	NO
SHORTNESS OF BREATH	YES	NO
DIZZINESS	YES	NO
UPPER RESPIRATORY INFECTION	YES	NO
URINARY TRACT INFECTION	YES	NO
ABDOMINAL PAIN OR PROBLEM WITH ULCER, HEARTBURN, HIATUS HERNIA OR GALLBLADDER PROBLEM	YES	NO
PAIN OR DIFFICULTY WITH JAW MOVEMENT	YES	NO
PULSATING HEADACHE	YES	NO
FAINTING OR BLACKOUT EPISODE	YES	NO
DOUBLE VISION OR BLURRED VISION	YES	NO
RINGING SOUNDS IN EARS	YES	NO
PROBLEMS WITH BALANCE	YES	NO

DATE OF LAST PHYSICAL EXAMINATION _____

THERAPIST'S SIGNATURE _____

CIRCLE YES OR NO

DO YOU HAVE A HISTORY OF:

ALLERGIES	YES	NO
HEADACHES	YES	NO
BRONCHITIS	YES	NO
KIDNEY DISEASE	YES	NO
RHEUMATIC FEVER	YES	NO
ULCERS	YES	NO
SEXUALLY TRANSMITTED DISEASE	YES	NO
SEIZURES/EPILEPSY	YES	NO
ANXIETY/DEPRESSION, ETC.	YES	NO
PAST OR RECENT TRAUMA	YES	NO
MVA, INJURY TO NECK OR HEAD	YES	NO
FRACTURES	YES	NO

ARE YOU CURRENTLY:

UNDER STRESS	YES	NO
PREGNANT	YES	NO
DEPRESSED	YES	NO

ARE YOUR SYMPTOMS: (CHECK)

___GETTING WORSE ___SAME ___IMPROVING

HOW ARE YOU SLEEPING?

___ FINE ___MODERATE DIFFICULTY

___ ONLY WITH MEDS

CHECK ALL THAT APPLY
DO YOU HAVE A PROBLEM WITH:
____ HEARING ___VISION _____SWALLOWING
____ SPEECH _____COMMUNICATION

DO/HAVE YOU SMOKED TOBACCO?
IF YES, _____ PACKS X _____ YEARS
LAST TOBACCO USE _____

DO YOU DRINK ALCOHOL? YES NO
HOW MANY PER WEEK? _____

PLEASE SEE REVERSE SIDE.....

PATIENT'S NAME_____ DATE_____

LIST CURRENT MEDICATIONS:_____

_____

_____

LIST OF SURGERIES (PLEASE LIST ALL SURGERIES AND APPROX DATES):_____

_____

_____

DIAGNOSTIC TESTS AND APPROX DATES (LIST THOSE ADMINISTERED FOR YOUR CURRENT PROBLEM ONLY)

_____XRAY_____CT SCAN_____MRI_____BONE SCAN_____

_____EMG_____BLOOD CHEMISTRY_____MYELOGRAM_____OTHER_____

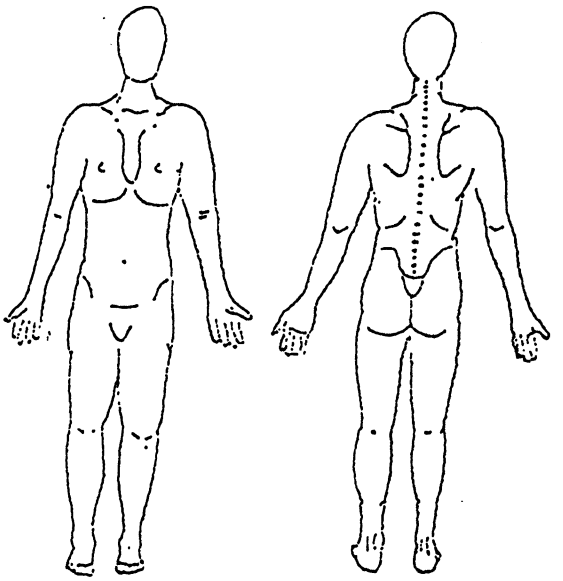
HAVE TOU SEEN ANYONE ELSE FOR YOUR CURRENT PROBLEM?

_____PHYSICIAN_____CHIROPRACTOR_____PODIATRIST_____PHYSICAL THERAPIST

_____ORTHOPEDIC_____DENTIST_____OTHER

PLEASE USE THE DIAGRAM BELOW TO IN DICATE THE SYMPTOMS YOU HAVE EXPERIENCED OVER THE PAST 24 HOURS. BE VERY PRECISE WHEN DRAWING THE LOCATION OF YOUR PAIN. USE THE KEY TO INDICATE THE TYPE OF SYMPTOMS>

KEY: PINS AND NEEDLES- OOOO
DEEP ACHE- ZZZZ
STABBING- ////
BURNING-XXXX



PLEASE RATE YOUR CURRENT LEVEL OF PAIN ON THE FOLLOWING SCALE(CIRCLE ONE)

0 1 2 3 4 5 6 7 8 9 10

(NO PAIN) (WORST IMAGINABLE PAIN)

PLEASE RATE YOUR WORST LEVEL OF PAIN IN THE LAST 24 HOURS (CIRCLE ONE)

0 1 2 3 4 5 6 7 8 9 10

(NO PAIN) (WORST IMAGINABLE PAIN)

PLEASE RATE YOUR BEST LEVEL OF PAIN IN THE LAST 24 HOURS (CIRCLE ONE)

0 1 2 3 4 5 6 7 8 9 10

THERAPIST'S INITIALS_____