Demographic and Insurance Information

Patient Name (Last, First, MI): _____

Date of Birth: _____ **Sex (Circle): M / F**

HOW DID YOU HEAR ABOUT US? (Please circle)		
MD Referral Family/Friend Advertisement Website Facebook/Instagram ZocDoc Other:_____		
PATIENT INFORMATION		
Street Address	City, State, Zip	Home Phone
Mailing Address (if different from above)	City, State, Zip	Cell Phone
Occupation	Currently employed [ ] YES [ ] NO	Social Security No.
School (If Student)	Marital status S M O	E-mail
PRIMARY CARE & EMERGENCY CONTACT		
Family / Primary Care Physician		Office Phone Number
Emergency Contact / Relation to patient /		Cell Phone Number:
If patient is a minor, PARENT/LEGALGUARDIAN NAME		
Parent/Legal Guardian Name (Last, First, MI)	Parent/Legal Guardian Date of birth	
Street Address (if different than above)	City, State, Zip	
Parent/Legal Guardian SS#	Cell Phone ( )	

HEALTH INSURANCE -POLICY 1 (Primary)				
Primary Carrier Name				Insurance ID#
Policy Holder (Last, First, M)	Sex	Relation to Patient	Date of Birth	Insurance Grp # Insured's Soc. Sec #
HEALTH INSURANCE -POLICY 2 (Secondary)				
Primary Carrier Name				Insurance ID#
Policy Holder (Last, First, M)	Sex	Relation to Patient	Date of Birth	Insurance Grp # Insured's Soc. Sec #

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MOTOR VEHICLE /WCOMP	
Is your Injury/Accident Related to: [ ] Work [ ] Motor Vehicle [ ] School	***If you have paperwork related to a workers compensation, motor vehicle, or school based claim please provide it to the front desk staff.* Thank you.**

Will the primary Insurance be Motor Vehicle OR Worker Compensation? * If Yes, Complete Information Below *

Are you currently unable to work due to your condition? [ ] Yes [ ] No

If yes, what was the last date you worked: _____

Date of Injury/Accident:		Claim Number:
State Where Injury Occured:	Adjuster's Name:	Carrier Name:
Phone:		Fax:
Employer Name:		Employer Address:

The information I have provided (all patient information/insurance information) is true to the best of my knowledge. If any information on these forms change during the course of patients' physical therapy treatment and/or prior to the balance being paid in full, I will contact Performance PT & SC with the updated information.

PATIENT SIGNATURE: _____ **DATE:** _____

(If patient is a minor and/or unable to sign, legal custodial guardian or parent must sign)

Physical Therapist Initial: _____ **Date:** _____

Medical History and Current Complaints

NAME: _____ **AGE:** _____

What is the main reason for your visit today?

_____

_____

When did your symptoms start?

_____

Is this your first time having this problem?

_____

Have you received any previous treatment for this problem? If yes, what?

_____

Are you currently or recently (past 6 months) experiencing any of the following symptoms? (Check Yes or No)								
Yes	No		Yes	No		Yes	No	
		Fever			Recent illness / infection			Nausea, Vomiting, or Diarrhea
		Chills / Sweats			Difficulty swallowing			Loss of coordination
		Shortness of breath			Cough			Increased pain at night / rest
		Fatigue			Changes in appetite			Traumatic events (accidents/falls)
		Headache			Changes in bowel/bladder function			Chest Pain or Pressure
		Dizziness / Lightheadedness			Vision Problems / Blurry Vision			Weakness
		Memory Loss			Loss of balance / Unsteady on feet			Difficulty speaking
		Feeling depressed or anxious			Loss of consciousness			Symptoms during or after a meal
		Weight loss or weight gain			Numbness / Tingling			Increased Stress
		Ringing in the ears			Swelling			Rash / Skin conditions
		Currently Pregnant			Pacemaker			Heart Palpitations

Have you ever been diagnosed with any of the following? (Check Yes or No)								
Yes	No		Yes	No		Yes	No	
		Cancer			DVT / Blood Clots			COPD
---	---	If yes, type:			Kidney Disease			Emphysema
---	---				Lyme Disease			Atrial Fibrillation
		Heart Disease			Autoimmune Disease			Fibromyalgia
		Diabetes (Type 1 or 2)			Stroke			Ulcer
		High Blood Pressure			Multiple Sclerosis			Crohn's Disease
		High Cholesterol			Parkinson's Disease			Irritable Bowel Syndrome
		Osteoporosis / Osteopenia			Brain Injury / Concussion			Fractures / Broken Bones
		Seizure / Epilepsy			Vertigo			Neuropathy
		Anemia			Thyroid Disease			Asthma

ARE YOU CURRENTLY TAKING OR HAVE A HISTORY OF TAKING THE FOLLOWING MEDICATIONS? (Please Circle)

Corticosteroids (Prednisone, Asthma inhaler, etc) Blood thinners (Xarelto, Coumadin, etc) Immunosuppressants NONE

PLEASE LIST PRESCRIPTION AND NON-PRESCRIPTION MEDICATION YOU ARE CURRENTLY TAKING (Include Dosage)

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STRESS			
How would you rate your stress level (Circle One): High Normal Low			
Recently, have you often been bothered by feeling down, depressed or hopeless?	YES	NO	
Recently, have you often been bothered by little interest or pleasure in doing things?	YES	NO	
Is this something with which you would like help?	YES	NO	YES, BUT NOT TODAY

ALLERGIES [ ] NONE KNOWN	
Are you allergic to latex? [ ] Yes [ ] No	**Are you allergic to tape / adhesive? [ ] Yes [ ] No**
Any other allergies? (Please List - medications, food, other)	

SURGERY	
Is your physical therapy visit related to a recent surgery: [ ] Yes [ ] No	
If your doctor provided you with a post-op protocol please allow us to make a copy to keep in your chart	
Surgery Date	Type of Surgery

PLEASE LIST ANY PREVIOUS SURGERIES, ANY OTHER CONDITION FOR WHICH YOU HAVE BEEN HOSPITALIZED OR ANY OTHER CONDITION WE SHOULD BE AWARE OF (SPECIFY THE APPROXIMATE YEAR WHERE APPROPRIATE)

HAVE YOU HAD PHYSICAL THERAPY THIS YEAR?
( ) YES ( ) NO SAME CONDITION? ( ) YES ( ) NO Number of Visits:
IF YOU HAVE HAD PHYSICAL THERAPY THIS YEAR FOR ANY CONDITION, PLEASE INFORM YOUR PHYSICAL THERAPIST.

EXERCISE
Do you currently exercise (Circle One): Yes No
Briefly describe what you like to do for exercise and how frequently you exercise:

What activities are your current symptoms stopping you from doing?

_____

_____

What is your goal for physical therapy care?

_____

_____

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