CORE
PHYSICAL THERAPY & SPORTS REHABILITATION, P.C.

PATIENT INFORMATION

EMAIL ADDRESS: _____

First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	Male Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -		Spouse:
Chose Clinic Because/ Referred to Clinic By Dr.:		Insurance Plan Family Friend	
Former Patient Close to Work/Home Website Yellow Pages Street Sign Other:			

WORK INFORMATION

Employer:	Work Phone ( ) -	Ext.
Occupation:	Employment Status Full Time Part Time Retired Not Employed	

CARE PROVIDER INFORMATION

Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance Name:		
Subscriber's Name (If different):		Birth date : / /
ID. #:	Group/Policy #	
Patient's Relationship to Subscriber: Self Spouse Child Other:		
Name of Secondary Insurance:		
Subscriber's Name:		Birth date : / /
ID. #:	Group/Policy #	
Patient's Relationship to Subscriber: Self Spouse Child Other:		

AUTO OR WORK INJURY CLAIM

(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)

Insurance Name: Auto :		Labor & Industries:	
Adjuster/Claim Manager:		Phone:	Ext.:
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

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ATTORNEY INFORMATION			
Name:	Law Firm:	Phone: ( ) -	
Address	City	State:	Zip:

IN CASE OF EMERGENCY		
Name of Local Friend or Relative (Not Living at Same Address):		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

I authorize my insurance benefits be paid directly to . I understand that I am financially responsible for any balance. I also authorize to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

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PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE	YES	NO
Hypertension		
Low Blood Pressure		
Normal Blood Pressure		

HEART DISEASE	YES	NO
Heart Attack		
Atherosclerotic Disease		
Myocardial Infarction		
Rheumatic Heart Disease		
Heart Murmur		
Do you have a pacemaker		

MUSCLE CONDITION	YES	NO
Carpal Tunnel R/L		
Tennis Elbow R/L		
Back/Neck Problems		
Limited Limb Movement		

LUNGS	YES	NO
Asthma		
Emphysema		
Shortness of Breath		

JOINT CONDITIONS	YES	NO
Upper Extremity		
Dislocation		
Lower Extremity Dislocation		

OTHER CONDITIONS	YES	NO
Muscular Dystrophy		
Rheumatoid Arthritis		
Multiple Sclerosis		
Epilepsy		
Gout		
Fibromyalgia		
Diabetes		
Hearing Loss		
Poor Eyesight		
Fainting		
Cancer (presently or history of)		

Other: _____

_____

_____

_____

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

What types of exercise do you perform? :

What things cause stress in your life? :

Are you taking any seizure medication? 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:

List all surgeries in the past two years (Including dates):

Are you pregnant? YES NO What week?:

Have you had any injuries related to work? YES NO If yes list body part and date.:

Have you had any Auto Accidents YES NO If yes list body part and date.:

Have you had Physical Therapy or Massage Therapy before? YES NO Where:

Signature of Patient, Parent, Guardian, Personal Representative

Date

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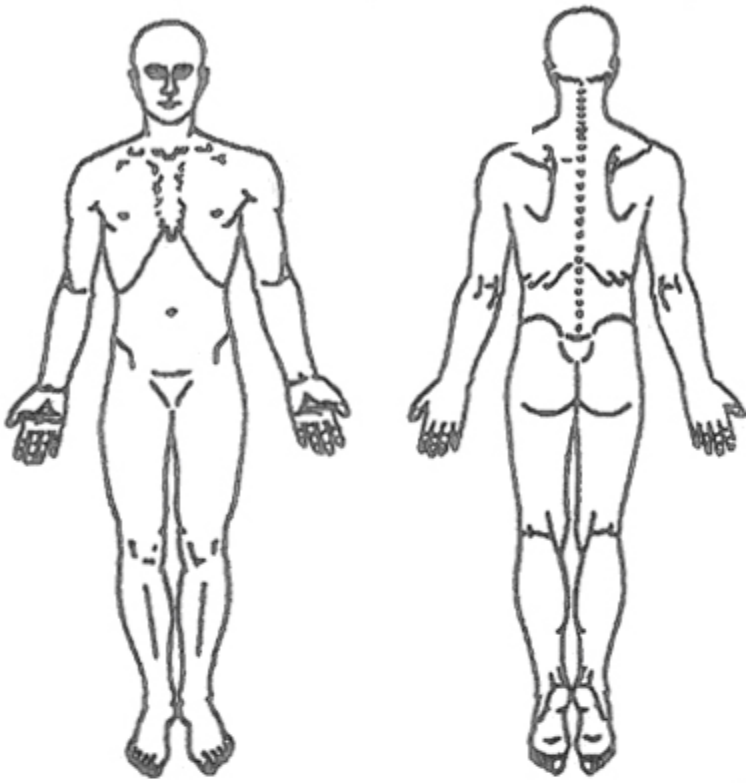
Pain and Symptom Status Report

Name: _____ **Date:** _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing

Ache	Burning	Numbness
MMM	— — —	O O O O
M	— —	O O O

Pins and Needles	Stabbing	Other
▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫	/ / / / / /	x x x x
▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫	/ / / /	x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____

Date First Symptom of your problem occurred on. _____

2nd Complaint _____

3rd Complaint: _____

Please circle on the scale below to indicate your CURRENT level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it gets.**

Please circle on the scale below to indicate your AVERAGE level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it gets.**

Please circle on the scale below to indicate your WORST level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it gets.**

Additional Comments _____