PTS PHYSICAL THERAPY SPECIALISTS

PATIENT INFORMATION SHEET / MEDICAL HISTORY

PATIENT EMAIL: _____

NAME: _____ DOB: _____ SOCIAL SECURITY: _____

ADDRESS: _____

HOME PHONE NUMBER: _____ CELL: _____ MARITAL STATUS: _____

☐CHECK IF YOU WOULD LIKE TO RECEIVE APPOINTMENT REMINDERS VIA TEXT MESSAGE

EMERGENCY CONTACT NAME: _____ RELATIONSHIP TO PATIENT: _____

PHONE NUMBER: _____ REFERRING DOCTOR: _____

WEIGHT: _____ HEIGHT: _____

PLEASE INDICATE ANY OF THE CURRENT CONDITIONS YOU HAVE, OR HAVE HAD IN THE PAST:

___CURRENTLY PREGNANT	___HIGH BLOOD PRESSURE	___HEART ATTACK
___BOWEL/BLADDER PROBLEMS	___MULTIPLE SCLEROSIS	___INTERNAL MEDICAL DEVICE
___SEIZURES	___DIABETES	___OTHER HEART CONDITION
___RECENT WEIGHT LOSS	___PARKINSON'S	___CIRCULATORY PROBLEMS
___CANCER	___PACEMAKER	___ACTIVE INFECTIONS
___DIZZINESS	___USE OF CORTICOSTERIODS	___NEUROPATHY
___STROKE / PARALYSIS	___RECENT SURGERIES	___OSTEOPOROSIS/OSTEOPENIA
___CONGESTIVE HEART FAILURE	___RENAL/KINDEY DISEASE OR DIALYSIS	___DEEP VEIN THROMBOSIS (DVT)
___CARDIAC EDEMA	___IRREGULAR HEARTBEAT	___ARTERY DISEASE

PLEASE DESCRIBE YOU CURRENT COMPLAINT: _____

_____

WHAT ACTIVITIES HAVE YOU NOT BEEN ABLE TO DO, OR HAVE YOU HAD TO ALTER THE WAY YOU DO SINCE THE ONSET OF YOUR CURRENT COMPLAINT? _____

_____

PLEASE LIST ANY MEDICATIONS/VITAMINS/SUPPLEMENTS YOU ARE CURRENTLY TAKING INCLUDING DOSAGES:

_____

_____

WHAT GOALS DO YOU HOPE TO ACHIEVE THROUGH PHYSICAL THERAPY? _____

HAVE YOU HAD ANY OTHER INJURIES OR SURGERIES IN THE PAST FIVE (5) YEARS? _____

HAVE YOU HAD ANY DIAGNOSTIC STUDIES REGARDING THIS CONDITION?_____

1. How did you hear about us? Circle one: Doctor Friend/Family Road Sign Internet Other_____

2 Is your injury the result of an automobile accident? Yes / No

4. Are you currently receiving any home health, nursing, or other medical care for this condition? Yes / No

5. Have you fallen in the past year? Yes / No . If so, how many times? _____

6. Under what circumstances? _____

7. Was an injury sustained during the fall? Yes / No

8. Are you involved in any litigation regarding this injury? If so what is the name of your attorney?

_____

SIGNATURE & DATE: _____

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BODY PAIN SCALE

Pain Rating Scale: Use the number scale that is listed below to describe the **CURRENT** INTENSITY of your pain.

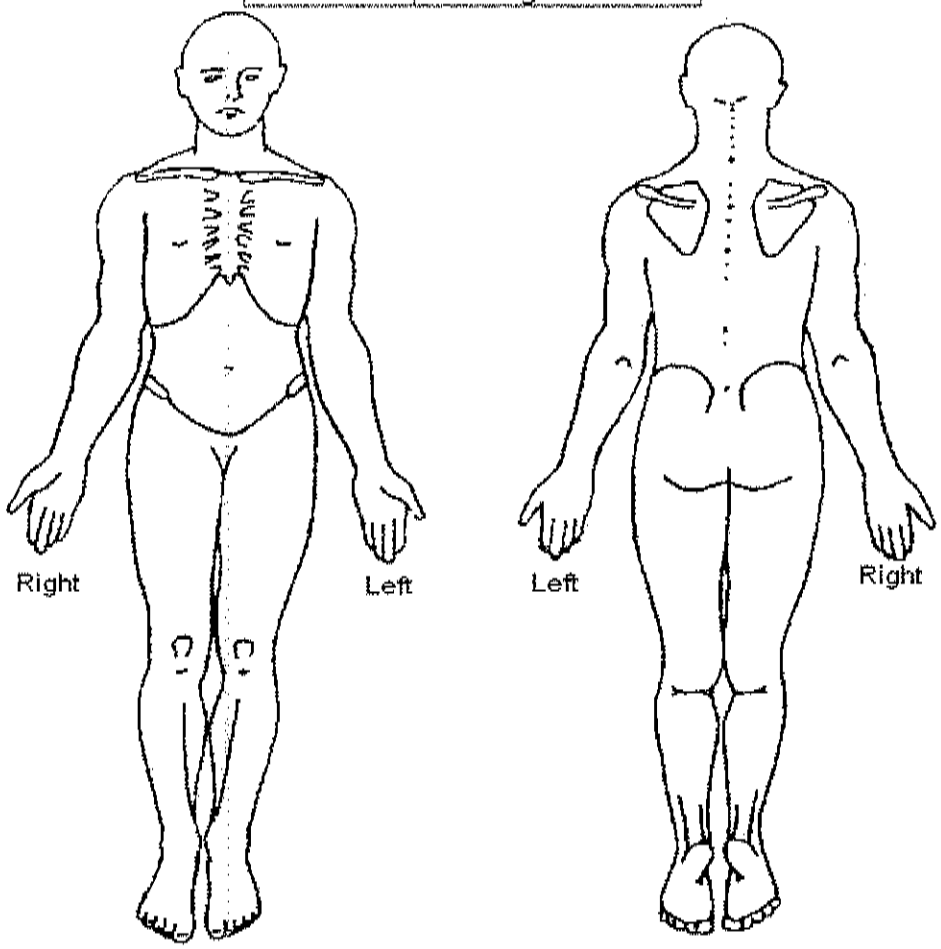
NO PAIN	LOW	MEDIUM	HIGH	SEVERE
0	1 2 3	4 5 6	7 8 9	10

Using the number rating system above, describe your pain:

In the past 30 days	Pain level at BEST:		(0-10)
In the past 30 days	Pain level at WORST:		(0-10)

Use the symbols listed below to describe the location and type of pain you are having by drawing them on the picture(s) above. Mark areas of radiation. Include all affected areas.

OOOO	Pins and Needles
//////	Numbness
√√√√√	Aching
XXXX	Stabbing
≡ ≡ ≡ ≡	Burning



Patient Signature: _____ Date: _____

(Parent or Guardian if patient is a minor)

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Effective 8/16/11

There will be a **$30.00 charge** for all missed visits if we are not given at least 24 hours' notice. This includes cancelled and no-show visits. This charge will be the patient's responsibility to pay (not the insurance carrier). Please be as respectful of our time as we are of yours. Thank you for your cooperation in this matter.

FOR WORKERS COMPENSATION PATIENTS:

It is our office's policy to notify your case manager and physician of all missed Physical Therapy visits. You must give at least 24 hours' notice if you will be unable to attend your scheduled appointment. Please make arrangements in advance with your employer to make sure all visits are attended. If you fail to make it to more than three scheduled therapy visits we reserve the right to discharge your care base on non-compliance.

Patient Signature & Date: _____

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