Clear Form

sports community physical therapy

Ari Levine, Physical Therapist

PATIENT INFORMATION			EMAIL ADDRESS:_____
First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	☐ Male ☐ Female	☐ Married ☐ Single ☐ Other	S.S. #: - -
Home Phone: ( ) -	Cell Phone ( ) -	Spouse's Name:	

WORK INFORMATION			
Employer:	Work Phone ( )	Occupation:	
Employer Address:	City	State:	Zip:
Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed ☐ Full-time Student ☐ Part-time Student			

REFERRAL/PHYSICIAN INFORMATION	
Chose clinic because: ☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Insurance Plan ☐ Family/Friend	
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 BACK UP)
Insurance Name: ☐ Auto :		☐ Labor & Industries:	
Adjuster/Claim Manager:		Phone:	Ext.:
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

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 Sports Community Physical Therapy. I understand that I am financially responsible for any balance. I also authorize Sports Community Physical Therapy 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	☐	☐
Fainting	☐	☐

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

MUSCLE/TENDON CONDITIONS	YES	NO
Carpal Tunnel R/L	☐	☐
Golfer's/Tennis Elbow R/L	☐	☐
Back/Neck	☐	☐
Hip/Knee/Ankle	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity	☐	☐
Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐
Arthritis	☐	☐

OTHER CONDITIONS	YES	NO
Muscular Dystrophy	☐	☐
Rheumatoid Arthritis	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
CANCER (previous or currently)	☐	☐

Other: _____

_____

_____

_____

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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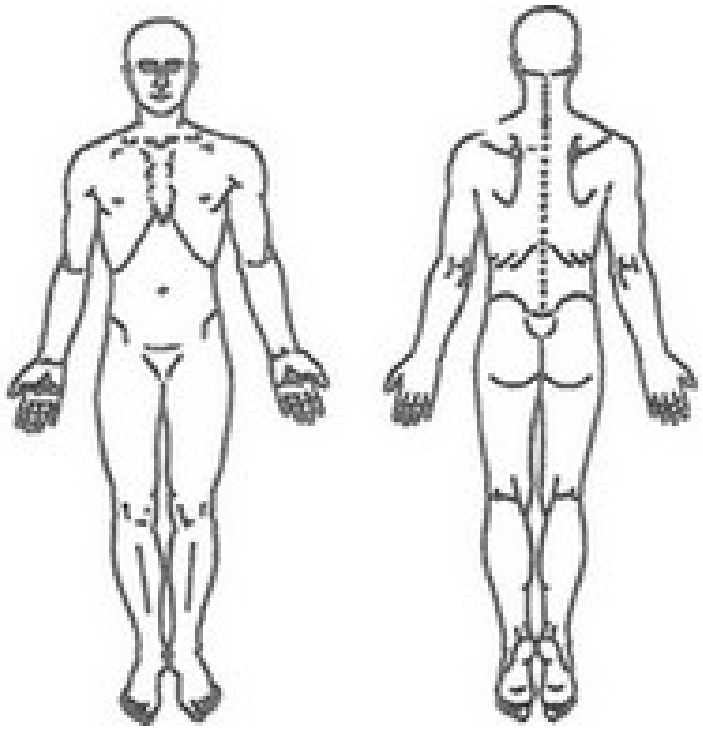
Pain and Symptom Status Report

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	--- --- ---	0 0 0 0
MM	--- ---	0 0 0

Pins and Needles	Stabbing	Other
p p p p	/ / / / / / /	x x x x
p p p	/ / / /	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

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