

Date: _____

Physical Therapy Specialists
Spine and Sports Rehab, Weight Loss and Wellness Center

PATIENT INFORMATION	
How did you hear about us? _____	Primary Care Physician _____ Referring Physician _____
Name _____ <small>Last First M.I.</small>	Sex M / F Marital Status M / D / S / W
Address _____	City _____ State ____ Zip _____
Home Phone _____	Emergency Contact _____ Ph # _____
Social Security _____ - _____ - _____	Driver's License _____ Date of Birth _____
E-Mail Address _____	Are you a previous patient? ___ Yes ___ No
Employed By _____	Phone # _____ Ext. _____
Employer Address _____	City _____ State _____
Name of Spouse or Parent _____	Relationship _____
Date of Birth _____	Social Security _____ - _____ - _____ Phone # _____
Employed By _____	Employer Phone _____

MEDICAL INFORMATION	
Part of body to be seen (Part and side of body) _____	What type of injury? <input type="checkbox"/> Auto Accident <input type="checkbox"/> Non-Accident <input type="checkbox"/> Industrial <input type="checkbox"/> Other
Onset of symptoms or date of accident _____	Where did injury occur? _____
Was there any time lost from work? <input type="checkbox"/> No <input type="checkbox"/> Yes From _____ to _____	Any notable medical problems (you may cont. on back) <input type="checkbox"/> No <input type="checkbox"/> Yes Describe: _____

INSURANCE INFORMATION	
<u>Primary Insurance</u>	<u>Secondary Insurance</u>
Insurance Company _____	Insurance Company _____
Insurance Phone _____	Insurance Phone _____
Member ID # _____	Member ID # _____
Policy Holder Name _____	Policy Holder Name _____
Birthdate _____	Birthdate _____
Group # _____	Group # _____
Relationship to Patient _____	Relationship to Patient _____

INDUSTRIAL INFORMATION	
Industrial Carrier _____	Adjustor _____ Phone _____
Address _____	Claim # _____ Injury Date _____
Attorney - _____	Phone # _____
Address _____	City _____ State _____

I HEREBY ASSIGN, TRANSFER, AND SET OVER TO **PHYSICAL THERAPY SPECIALISTS** ALL MY RIGHTS, TITLE, AND INTEREST TO MY MEDICAL REIMBURSEMENT BENEFITS UNDER MY INSURANCE POLICY. I HEREBY AUTHORIZE TREATMENT FOR MY MEDICAL CONDITION. I ALSO ACKNOWLEDGE RECEIPT OF THE HIPPA NOTICE AND ADVANCE BENEFICIARY NOTICE REGARDING MEDICAL SUPPLIES AND AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NEEDED FOR CONTINUITY OF CARE.

X _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN

X _____
SIGNATURE OF INSURED



PATIENT QUESTIONNAIRE

Name: _____ Date: _____

Age: _____ Sex: Male or Female (circle one) Handed: Left or Right (circle one)

Height: _____ Weight: _____

Have you been a patient here before? _____ If yes, when? Month/Year: _____

PLEASE LET US KNOW WHO REFERRED YOU HERE

Please take a moment to tell us exactly how you found out about our facility.

1. Doctor? Name: _____
2. Family Member/Friend? Name: _____
3. Mailer? (Please indicate what you received in the mail) _____
4. Worker's Comp Adjuster Referral? _____
5. Yellow Pages? _____
6. Website? _____
7. Insurance Company/Website Listing? _____
8. Advertisement: which one? _____

DATE OF INJURY OR ONSET OF SYMPTOMS: _____

DESCRIBE HOW YOUR INJURY OCCURRED: _____

1. Have you had treatment for this/these problems before? _____

If yes, where and when were you treated? _____

2. Have you had surgery related to this/these problems? Yes / No

If yes, what type of surgery did you have and when was the surgery? _____

3. Have you had any injections for your current problem? Yes / No If yes, location: _____

4. Have you ever had or do you currently have any of the following?

Allergies/Asthma	Yes	No	Hernia	Yes	No
Balance Problems	Yes	No	High Blood Pressure	Yes	No
Cancer	Yes	No	Incontinence (bowel or bladder)	Yes	No
Circulatory Problems	Yes	No	HIV/AIDS	Yes	No
Diabetes	Yes	No	Kidney Problems	Yes	No
Dizzy Spells	Yes	No	Nervous Disorder	Yes	No
Fractures	Yes	No	Pregnancy (currently)	Yes	No
Headaches	Yes	No	Stroke or Parkinson's	Yes	No
Hearing Problems	Yes	No	Seizures	Yes	No
Heart Attack	Yes	No	Sensitive to heat/ice	Yes	No
Heart Disease	Yes	No	Vision Problems	Yes	No

If yes on any of the above, please explain and give approximate dates:

5. Do you currently have any metal implants? Yes No

6. Do you currently have a pacemaker? Yes No

7. Do you have any communicable diseases? Yes No

8. Do you smoke? Yes No

9. List any medications you are currently taking: _____

DESCRIPTION OF SYMPTOMS & FUNCTIONAL LIMITATIONS

CURRENT COMPLAINT: _____

TYPE OF PAIN (circle a maximum of 2): shooting burning aching sharp dull other: _____

HOW OFTEN DO YOU HAVE THIS PAIN? _____ x week Every A.M. With Activity: _____

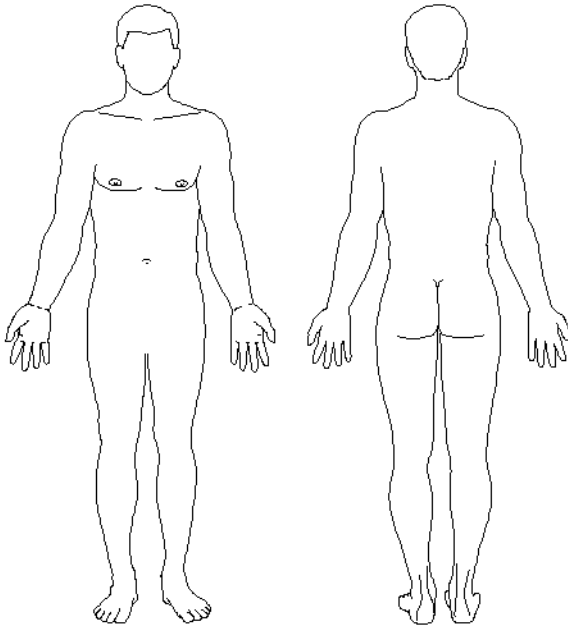
Please circle below all that apply: Please indicate on the diagram where you experience your pain/symptoms.

PAIN NUMBNESS WEAKNESS TINGLING

HEADACHES: _____ x per week

MY PAIN IS INCREASED BY: _____

MY PAIN IS DECREASED BY: _____



What activities in your daily life are affected the most by your current complaint? _____

If you have limitations/restrictions at your job, what are they? _____

What are you goals for the first 2 weeks? _____

What are your goals at 6-8 weeks? _____

REPORTS FOR YOUR PHYSICIANS

We will be sending an evaluation and monthly progress reports to the physician who referred you to our office.

In addition, we would like to include your family physician (if you were referred by a specialist) and/or any other physicians whose care you are under (neurologists, pain specialists...). Please include their information so we can keep them updated on your care.

Doctor's Name (First, Last): _____ Phone # _____

Address: _____ City/State/Zip: _____

Authorization to Release Protected Health Information

Physical Therapy Specialist

1804 North Placentia Ave.

Placentia, CA 92870

Telephone: (714) 528-9400

Fax: (714) 528-9403

By signing below, I authorize the above named facility to use and/or disclose the following Protected Health Information (PHI): _____

Describe the Protected Health Information you are authorizing to be used and/or disclosed

This information may be used and/or disclosed for the purpose of _____

Describe each purpose for which you are authorizing the use or disclosure

If applicable, I authorize the facility named above to disclose this information to _____

This authorization expires _____
Date of event upon which authorization expires

I understand that once the information is released it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by notifying, in writing, the above-named facility. However, a revocation will not affect any actions taken by the above-named facility prior to their receipt of the revocation.

I understand that my treatment can cannot be conditioned on whether I sign this authorization. I understand I may refuse to sign this authorization.
(Select one and check box.)

Signature of Patient, Parent, Guardian, or Personal Representative

Date

Please print name of Patient, Parent, Guardian, or Personal Representative

Date

A COPY OF THIS SIGNED AUTHORIZATION MUST BE PROVIDED TO THE PATIENT