State College Physical Therapy, Inc. dba Anaheim Hills Physical Therapy and Rehabilitation

Thank you for choosing our office. In order to serve you, we need the following information (Please print). All information will be strictly confidential.

Patient's Name: (Last, First, Middle)

Marital Status: Single ☐ Married ☐ Widow ☐ Divorced ☐

Birth date: Age Sex Male ☐ Female ☐

Residence address:

Home Phone # Work Phone # Cell Phone #

Social Security # Drivers License #

Occupation: Name of Employer:

Employer Address: Employer Phone #

Person Financially responsible for this account:

Address: Phone #

If child, Parent's or Guardian's name:

Emergency Contact Relationship to patient Phone #

Do you have medical insurance? Yes ☐ No ☐
If yes, is it through your employer? Yes ☐ No ☐

Insurance Co. Name and address:

Subscriber name: Policy Number:

PPO ☐ HMO ☐ POS ☐ Medicare ☐ Medical ☐ Other ☐ _____

If you do not have medical insurance. How do you intend to pay? Cash ☐ Check ☐

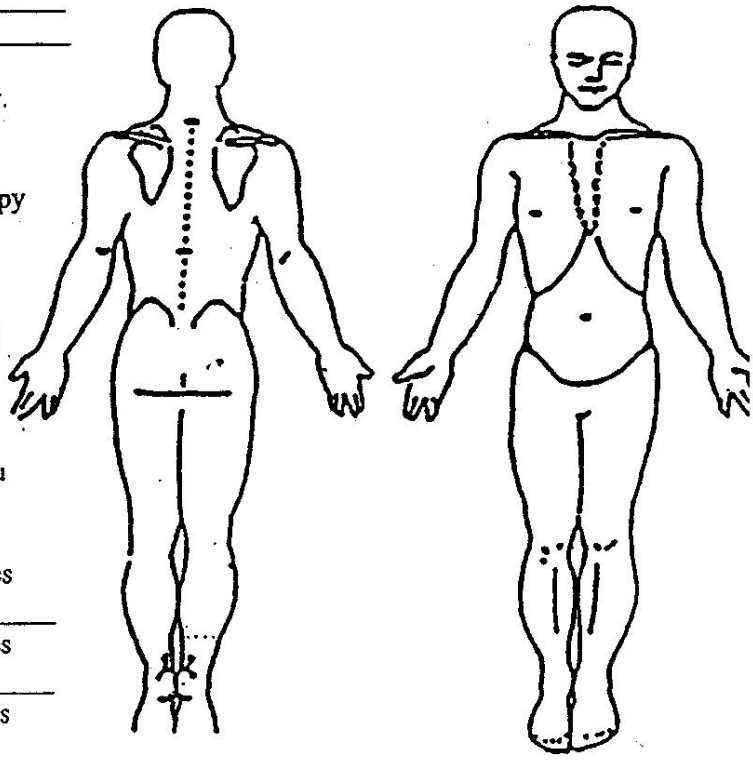
Who may we thank for referring you?

I have read and fully understand this office's Notice of Information Practices. I hereby consent to the use and disclosure of my personal health information for purposes as noted in this office's Notice of Information Practices. I understand that I retain the right to restrict how my personal health information is used or to revoke this consent by notifying the practice in writing at any time.

Patient's, Parent's or Guardian's Signature _____ Date _____

PATIENT HISTORY AND PHYSICAL CONDITION FORM

Name:_____
Phone:_____ **Date:**_____
Occupation:_____ **Age:**_____



1. Briefly describe the problem that brings you here today.

If pain is part of your reason for coming to Physical Therapy
How would you rate your overall daily pain level.

(No pain-0) 1 2 3 4 5 6 7 8 9 10 (10-worst possible)
MIN MOD SEVERE

2. Shade in on the body chart for (current condition) if you have any areas of:
   - ☐ PAIN: Where?_____
     - ☐ Always there ☐ Comes and goes
   - ☐ NUMBNESS (loss of feeling): Where?_____
     - ☐ Always there ☐ Comes and goes
   - ☐ TINGLING (pins and Needles): Where?_____
     - ☐ Always there ☐ Comes and goes
   - ☐ WEAKNESS Where?_____
     - ☐ Always there ☐ Comes and goes

3. What particularly makes your problem worse? Are there activities you are avoiding or doing less of because of your problem? Examples walking, climbing stairs, reaching overhead, backing up the car and prolonged sitting.

4. What positions or activities make your problem better? Example (lying down, sitting, etc.

5. Is there a particular time of day that your problem is at its worst?
   ☐ MORNING ☐ AFTERNOON ☐ EVENING ☐ NIGHT

6. Does any part of your problem wake you up after you have fallen sleep?

7. When did this problem first appear and how did it begin? (was there a particular cause?)

8. Have you ever had any of these same problems in the past? If so when?

Two sided questionnaire please turn to complete other side → → →

9. Overall is your problem:

☐ GETTING WORSE ☐ GETTING BETTER ☐ STAYING THE SAME

10. What other treatments have you had so far for current condition?

☐ PHYSICAL THERAPY: How many treatments?____When?____ Helped? ☐ YES ☐ NO

Treatment: ☐Exercise ☐Heat/Ice ☐Ultrasound ☐Traction ☐Hands on therapy ☐Electric stimulation

☐ CHIROPRACTOR: How many treatments?_____When?____ Helped?_____

☐ INJECTIONS: When?_____Helped?_____

☐ SURGERY: What?_____When?_____Helped?_____

☐ OTHER:_____

11. MEDICATIONS: please check if taking, and circle the ones that have helped. List all your medications.

☐ Motri/Naprosyn/clinioril ☐ Robaxin ☐ Soma ☐ Elavil
☐ Flexeril ☐ Percet (Roxicet) ☐ Tylenol ☐ Vicodin
☐ Neurontin ☐Prednisone (steroid) taper When?_____ ☐ Celebrex
☐ Other_____

12. Are you currently off of work because of your problem? ____YES_____NO If so, how long?_____

13. Do you have any regular exercise ? If so, what?_____

14. What are your Expectations/ Goals for Physical Therapy?_____

15. Have you had any diagnostic test done? Please specify body part(s) imaged.

☐ XRAY: When?_____ ☐ MYELOGRAM: When?_____
☐ CT Scan: When?_____ ☐ MRI: When?_____ ☐OTHER: When?_____

16. General Health

☐ Broken bones: Which bone?_____ When?_____
☐ Motor vehicle accident: When? _____
☐ Cancer: What_____ When_____ Current status?_____
☐Chemotherapy ☐Radiation ☐Surgery
☐ Heart Problems: What?_____When?
☐ Asthma/Lung problems ☐ Vascular disease (poor blood flow)
☐ Diabetes: Type I or II ☐ High Blood Pressure
☐ Stroke: When?_____ ☐ Long Term Steroid use (more than 3 months)
☐ Unexplained weight loss: When?_____ ☐ Depression?_____
☐ Pacemaker ? ☐ Allergies
☐ Surgical History: What and When?_____
☐ Any Metal Implants ? _____
☐ Other problems: What?_____ When?_____

Patient's signature:_____ **Date:** _____