TODAY'S DATE ______________________________

Legal Name: ____ **Date of Birth**: _____/_____/_____ **Age**: _______

(First) (M.I.) (Last)

Nickname: ______________________________ **Social Security #**: _______/_______/_______ **Gender**: _____ Male _____Female

Street Address: ____ **City**: __________________ **State**: __________ **Zip**: _______________

Billing Address If Different Than Above (i.e. PO Box):____

Cell #: ______________________________ Okay to Call? Yes No **Would you like to receive automated appointment reminders?** Yes No

Home #: ______________________________ Okay to Call? Yes No **Circle which phone you would like the reminder to go to**: Home Cell

Work #: ______________________________ Okay to Call? Yes No

Martial Status: Single Married Partnered Divorced Widowed Separated

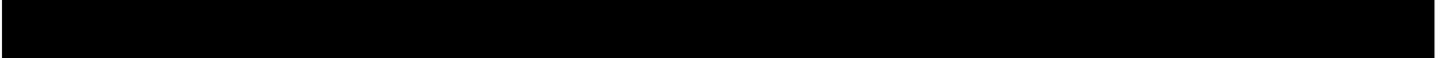
Spouse/Partner Name: __________________________________**Spouse/Partner Birthdate**:
_________/_________/_________**SS#**:_______/_______/_________

Spouse/Partner Employer: ____ **Employer Phone #**:
____

Are you Currently: Employed Unemployed Retired Disabled Military Student (Full-time or Part-time) Name of School:_________________________

Employer: ____________________________________ **Address**: ______________________________**Occupation**:________________________________

Referring Physician:____________________________ **Next Physician's Appointment Date**: _____/_____/_____**Primary Physician**: _________________



Full Name: ____**Relationship to Patient**: ____

Emergency Home #:________________________ **Emergency Cell #**: ________________________ **Emergency Work #**: ________________________

Father's Name:____

Address (If different from above):____________________________________
____

Home #:______________________ Cell #:______________________

Date of Birth: _______/_______/_______ SS#: ______/______/______

Employer:____

Employer's Phone #: ____

Mother's Name: ____

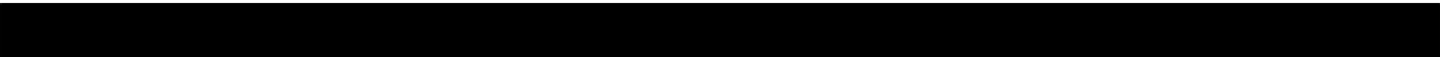
Address (If different from above):_________________________________
____

Home #:______________________ Cell #:______________________

Date of Birth: _______/_______/_______ SS#: ______/______/______

Employer:____

Employer's Phone #: ____



Responsible Billing Party: ___________________________________**Relationship to Patient:** Self Parent Spouse Legal Guardian Power of Attorney

If you are NOT a returning patient, how did you hear about PTSR or whom may we thank for recommending our clinic? (circle one)

Doctor: ___________________________ Church ____________________ Radio

Friend: ___________________________ Internet Newspaper

Coach: ___________________________ Sign Other ___________________________

What will we be treating you for and how did your symptoms begin?

____

____

Describe the location of your pain: ____

Is the condition due to an accident or injury? Yes No **If yes, it is related to:** Work Auto Other

Date of Accident/Injury: ______/______/______

Please describe your symptoms (i.e. ache, sharp, dull, burning, constant, intermittent, etc.)______________________________

Are your symptoms: Getting Better Getting Worse Not Changing

How are you able to sleep at night?: Fine With Moderate Difficulty Only with Medication **Hand Dominance**: Right Left

Have you had any X-ray, ultrasounds, CT scans, MRI, or other imaging done recently? Yes No

If yes, what?______________________________**When?**__________________________**Results**:________________________________

Did you have surgery for this condition? Yes No **If yes, date of surgery**: _______/_______/_______

Within the current year, have you received any treatment at another facility including physical therapy, occupational therapy, speech therapy, or chiropractic services? Yes No

If yes, please describe what treatment you received and when:____

Please list any surgeries that you have ever had and the date(s):

Please list all of your current medications:

Do you currently use tobacco? Yes No **Have you used tobacco in the past?** Yes No

Do you have a pacemaker? Yes No **Are you currently or could you be pregnant?** Yes No

Do you have a history of any of the following? (If yes, circle all that apply)

Cancer
Stroke
Allergies (Please Describe) ______________________
Diabetes
Osteoarthritis
Headaches
Autoimmune Deficiency
Rheumatoid Arthritis
Seizures
High Blood Pressure
Hepatitis
Adhesive/Latex Allergy
Heart Disease
Blood Born Diseases (HIV, HEPC, Etc.)
Depression
Angina/Check Pain

In the past 3 months, have you had or experienced any of the following? (If yes, circle all that apply)

Numbness/Tingling
Leg/Ankle Swelling
Weakness/Fatigue
Unexplained Weight Loss
Shortness of Breath
Changes in Bladder/Bowel Function
Dizziness

Have you received treatment from a skilled nursing facility or home health care in the last 30 days? Yes No

I, VOLUNTARILY, CONSENT TO PHYSICAL OR OCCUPATIONAL THERAPY TREATMENT AND SERVICES DEEMED MEDICALLY NECESSARY BY MY THERAPIST AND/OR PHYSICIAN. I FURTHER ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE RESULTS OF THESE SERVICES AT PHYSICAL THERAPY AND SPORTS REHAB OF HASTINGS.

______________________________ ______________________ ______________

Signature (Must be 18 years old to sign) Relationship to Patient Date