Weiss Physical Therapy Associates, PC

PATIENT INFORMATION			**EMAIL ADDRESS:**_____
First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	☐ Male ☐ Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -		Spouse:
Chose Clinic Because/ Referred to Clinic By ☐ Dr.:		☐ Insurance Plan ☐ Word of Mouth	
☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Advertisement			

WORK INFORMATION		
Employer:	Work Phone ( ) -	Ext.
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION	
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 #	Policy Holder's SSN:
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:		
Name of Secondary Insurance:		
Subscriber's Name:		Birth date : / /
ID. #:	Group/Policy #	Policy Holder's SSN:
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:		

AUTO OR WORK INJURY CLAIM	**(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)**		
Insurance Name: ☐ Auto :	☐ Labor & Industries:		
Adjuster/Claim Manager:	Phone:		Ext.:
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

ATTORNEY INFORMATION	**Is there pending litigation concerning your injury?** ☐ Yes ☐ No		
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: ( ) -
Please provide the name of the person(s) to whom Weiss Physical Therapy Associates, P.C. may disclose health information:		
Name:	Relationship to Patient:	Phone: ( ) -
May we send an email or leave messages regarding appointments or treatment on your answering machine? ☐ Yes ☐ No		

I have read and agree to the above, including the authorization to disclose my health information to the named recipient(s):

Patient Name (Print): _____ Date: _____

PATIENT /GUARDIAN SIGNATURE DATE

Weiss Physical Therapy Associates

PAST MEDICAL HISTORY FORM **Patient Name** _____

BLOOD PRESSURE	YES	NO
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Arrhythmia(s)	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
Do you have a pacemaker	☐	☐

MUSCLE CONDITION	YES	NO
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐
Muscular Dystrophy	☐	☐
Limited Limb Movement	☐	☐

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

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

OTHER CONDITIONS	YES	NO
Carpal Tunnel R/L	☐	☐
Parkinson's Disease	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Polio	☐	☐
High Cholesterol	☐	☐
Osteoporosis	☐	☐
Anxiety	☐	☐
Cancer	☐	☐
Depression	☐	☐
Stroke	☐	☐
Thyroid Condition	☐	☐
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			
	☐ Other			

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 (include 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

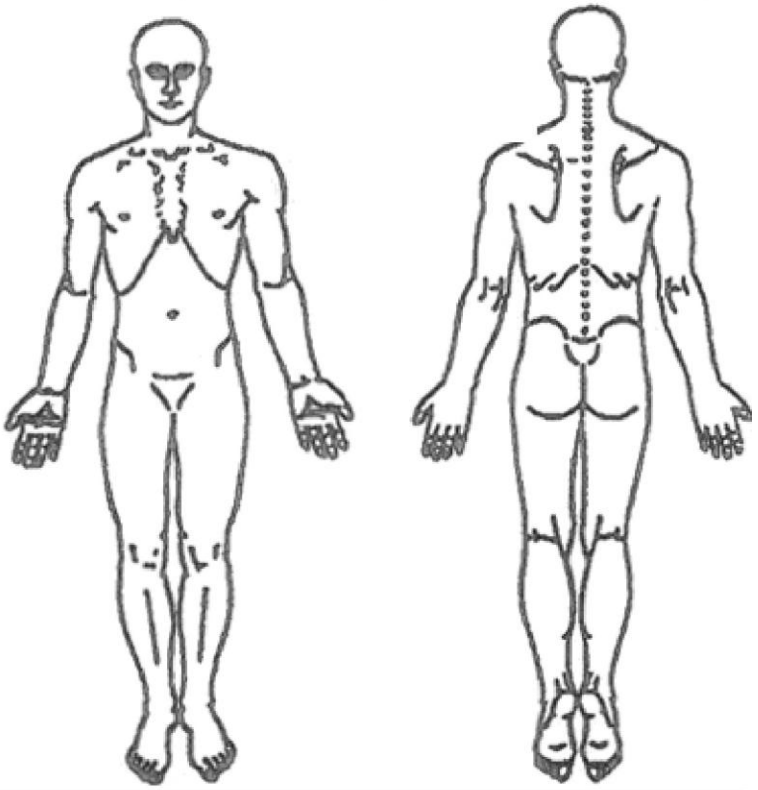
Pain and Symptom Status Report

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	— — —	O O O O
M	— —	O O O

Pins and Needles	Stabbing	Other
o o o o o o o o o	/ / / / / /	x x x x
o o o o o o o o	/ / / /	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 LOWEST 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 HIGHEST level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Additional Comments _____

_____

What goals do you wish to achieve in physical therapy? _____

_____