Weiss Physical Therapy Associates, PC

PATIENT INFORMATION

First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Email Address:			
Birth Date: / /	Age:	☐ Male ☐ Female	SSN: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -	Spouse:	

Chose Clinic Because/ Referred to Clinic by Dr.: _____ ☐ Insurance Plan ☐ Word of Mouth: _____

☐ I am a Former Patient ☐ Close to Work/Home ☐ Web Search/Website ☐ Drive-by ☐ Advertisement

WORK INFORMATION

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

CARE PROVIDER INFORMATION

Referring Dr:	Phone: ( ) -
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 #:	
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:	

IN CASE OF EMERGENCY

Name of Local Relative or Friend:		
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, PC

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 (including dates): _____

Are you pregnant? ☐ Yes ☐ No If yes, 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 If yes, where?

_____ _____

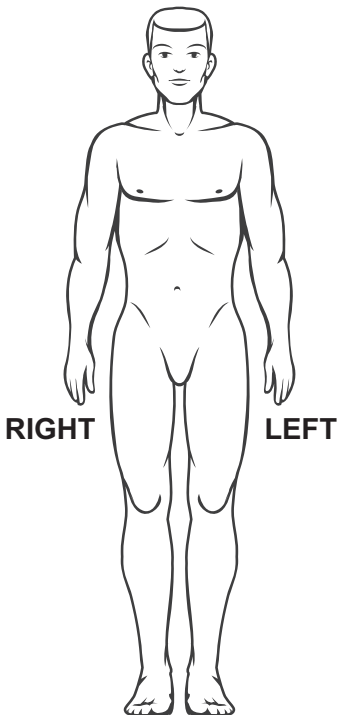
Signature of Patient, Parent, Guardian, Personal Representative Date

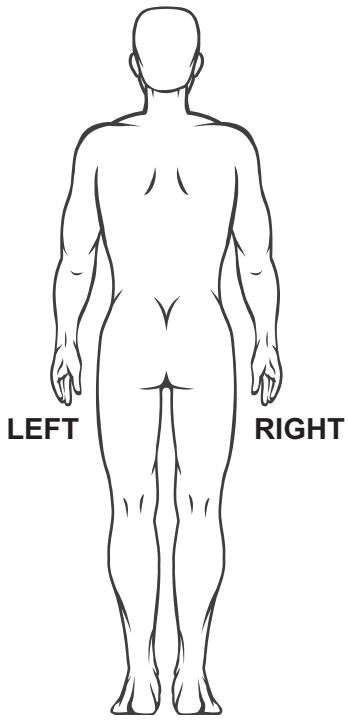
Pain and Symptom Status Report

Name _____ Date _____

Using the symbols below, please draw at the location on the body outlines, they type of pain you are experiencing.

Ache	Burning	Numbness
MMM M	— — — — —	0 0 0 0 0 0 0
Pins and Needles	**Stabbing**	**Other**
□ □ □ □ □ □ □ □ □ □	/ / / / / / / / /	x x x x x x x





Chief Complaint and Visual Analog Scale

Chief Complaint: _____

Date First Symptom of Problem Occurred: _____

2nd Complaint: _____

3rd Complaint: _____

Please circle on the scale below to indicate your <u>CURRENT</u> 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 <u>LOWEST</u> 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 <u>HIGHEST</u> 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? _____

_____

_____

_____

_____