Patient Name: _____

Doctor who referred you _____

Primary Care Physician _____

How would you prefer appointment reminders?

☐ Text ☐ Email

Employment Status

☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed

☐ Student Full Time ☐ Student Part Time

☐ Homemaker ☐ Other _____

_____

Employer Name

_____

Employer Number

Martial Status ☐ Married ☐ Single ☐ Divorced ☐ Widow

Gender ☐ Male ☐ Female

Social History

Are there any customs, religious beliefs or wishes you would like your therapist to be aware of? ☐ No ☐ Yes Explain:

With Whom do you live? (Choose one)

☐ Alone ☐ Spouse Only

☐ Spouse and other(s) ☐ Child

☐ Other relative ☐ Personal Care attendant

☐ Other _____

Have you had **ANY** therapy or chiropractic care in the last 2 years?

No Yes Explain: (same or different condition)

_____

Have you had **ANY** home health, nursing or hospice care in the last 3 months?

No Yes Explain:

_____

If you are receiving ANY home nursing care your therapy may NOT be covered by your insurance

LIVING ENVIRONMENT

Does your home have?

☐ Stairs, no railing ☐ Stairs, railing

☐ Ramps ☐ Elevator

☐ Uneven terrain ☐ Assistive Devices (bathroom)

☐ Other obstacles _____

ASSISSTIVE DEVICES

Do you use?

☐ Glasses ☐ Hearing aid

☐ Cane ☐ Crutches

☐ Walker without wheels ☐ Walker with 2 wheels

☐ Walker with 4 wheels ☐ Manual Wheelchair

☐ Motorized wheelchair ☐ Other _____

GENERAL HEALTH STATUS

Rate your overall health

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you had any major life changes during the past year?
(new baby, job change, death in the family, etc)

☐ No ☐ Yes _____

Do you smoke? ☐ Yes ☐ No Cigarettes per day _____

If you smoked in the past, year quit? _____

How many alcoholic drinks do you consume and how often?

_____ Drinks ☐ Per day ☐ Per week

Do you exercise beyond normal daily activities and chores?

☐ No ☐ Yes Days per week you exercise_____

What type of exercise?

Height_____ Weight _____

MEDICAL HISTORY

Allergies: _____

List all surgeries you have had including year: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY *Please check if you have ever had:*

☐Arthritis ☐Broken bones
☐Osteoporosis ☐Blood disorders
☐Heart problem ☐High blood pressure
☐Lung Problem ☐Stroke
☐Diabetes ☐Hypoglycemia (low blood sugar)
☐Head Injury ☐Multiple Sclerosis
☐Muscular dystrophy ☐Parkinson disease
☐Seizures/epilepsy ☐Allergies
☐Thyroid problem ☐Developmental (growth) problem
☐Cancer ☐Tuberculosis
☐Hepatitis ☐Kidney Problems
☐Repeated infections ☐Ulcers/stomach problems
☐Skin diseases ☐Depression
☐Pacemaker ☐Fibromyalgia
☐Hernia ☐Migraines
☐Concussion ☐Asthma
☐AIDS/HIV ☐Anemia
☐Appendicitis ☐Circulation/vascular problems
☐Other _____

Within the past year have you had any of the following?

☐Chest pain ☐Difficulty sleeping
☐Heart palpitations ☐Loss of appetite
☐Cough ☐Nausea/vomiting
☐Hoarseness ☐Difficulty Swallowing
☐Shortness of breath ☐Bowel problems
☐Dizziness or blackouts ☐Weight loss/gain
☐Coordination problems ☐Urinary problems
☐Headaches ☐Weakness in arms or legs
☐Fever/chills/sweats ☐Loss of balance
☐Difficulty walking ☐Hearing problems
☐Joint pain or swelling ☐Vision problems
☐Pain at night ☐Other _____

Men: Prostate disease ☐Yes ☐No

Women: ☐Pelvic inflammatory disease ☐Endometriosis
☐Trouble with your periods ☐Complicated pregnancy
☐Currently pregnant
☐Other _____

Have you fallen in the past 12mo's ☐ Yes ☐ No
If yes, how many times? _____

Have falls resulted in injury? ☐ Yes ☐ No
Do you have difficulty with walking/ balance? ☐Yes ☐No

MEDICATIONS

List all medications (Prescriptions and non-prescription) you are Currently taking.

Name Dosage (mg) Frequency(# per day)

_____
_____
_____
_____
_____

HISTORY OF PRESENT ILLNESS

Describe the general problem for which you are here today:

_____
_____

When did this problem Begin? ☐☐ ☐☐ ☐☐
Month Day Year

Did you have Surgery for this Problem? ☐No ☐Yes
Date of Surgery ☐☐ ☐☐ ☐☐
Month Day Year

Did you stay overnight in the Hospital? ☐No ☐Yes
Date of Discharge from Hospital ☐☐ ☐☐
Month Day

How did this injury happen? _____
Have you ever had a similar problem before?

☐No ☐Yes What did you do for the problem?_____
What makes the problem(s) better?_____

What makes the problem(s) worse?_____

Current weight bearing/lifting restrictions:_____
Are you ☐Right Handed ☐Left Handed
Are you seeing anyone else for the problem(s)?
☐Acupuncturist ☐Cardiologist ☐Chiropractor
☐Dentist ☐Family Doctor ☐Internist
☐Neurologist ☐Osteopath ☐Pediatrician
☐Podiatrist ☐Rheumatologist ☐Message Therapist
☐Obstetrician/gynecologist ☐Occupational Therapist
☐Orthopedic Surgeon ☐Other _____
What diagnostic tests have been performed for this problem?
☐X-ray ☐CT scan ☐MRI ☐Other _____

WORK RELATED INJURIES

Is the injury related to a work injury? ☐No ☐Yes
Date of Injury: _____
Current work status:
☐Full time regular duty ☐Full time light duty
☐Part time regular duty ☐Part time light duty
☐Unable to work due to injury ☐Unemployed
Describe your regular work duties prior to your injury:___
_____

Current work restrictions: _____

CAR ACCIDENT INJURIES

Is the injury related to a car accident? ☐No ☐Yes
Date of Accident: _____
Describe in detail what happened: _____
_____

Were you taken in an ambulance to a hospital? ☐No ☐Yes
If No, when did you first seek medical attention for your injuries? Exact date: _____
Were you ever treated for this pain/problem prior to this accident?
☐No ☐Yes Explain: _____

PATIENT SPECIFIC FUNCTIONAL AND PAIN SCALES

Last Name _____ First Name _____ Today's Date: _____

Please list 3 activities in your life you are unable to perform or having the most difficulty performing as a result of your injury or problem. *Three (3) functional limitations are REQUIRED by your insurance company to justify coverage for your treatment.*

0 1 2 3 4 5 6 7 8 9 10

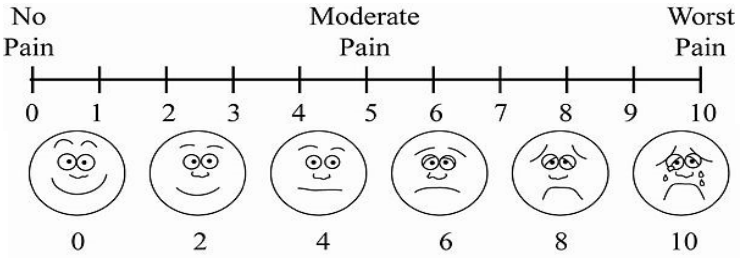
0 = Unable to perform activity

10 = Able to perform activity same as before injury

Activity Description (see below examples)	Score 0-10

Examples: Walking more than 15 minutes, sitting longer than 20 minutes, sleeping on my right side, specific work duties, housework or vacuuming, typing at my computer, carrying groceries, walking without assistive device, walking up/down stairs, blow drying hair, bathing or dressing independently, playing sports, hiking, lifting children, caring for parent or spouse.

What is your average daily pain? Circle one number below.



Consent to Treatment

I understand that I have been referred for Physical Therapy treatment to 360 Physical Therapy, LLC. 360 Physical Therapy, LLC has described for me my individual treatment plan. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to this treatment plan that has been prescribed by my physician and/or recommended by my therapist. By signing this agreement, I consent to have 360 Physical Therapy, LLC provide treatment and care as prescribed by my physician and/or recommended by my therapist.

Signature _____ Date _____

HIPAA

Patient's Written Acknowledgement of Notice of Privacy Practices:

I_____, acknowledge that I have been granted access to the notice of privacy practices and was given the ability to request a copy of 360 Physical Therapy's Notice of Privacy Practices and fully understand. I further acknowledge I have had all my questions answered to my satisfaction.

I hereby authorize 360 Physical Therapy to disclose my protected health information to the following:

_____ _____

Name Relationship to patient

_____ _____

Name Relationship to patient

Patient/ Guardian Signature:_____Date: _____

Consent to treat a minor

I hereby state that I am the legal guardian for the below referenced patient and I authorize the physical therapists and whomever they may designate as assistants at 360 Physical Therapy to administer physical therapy treatment care as deemed necessary to my minor child. I understand that at any time I am responsible for communicating any questions I may have in regards to treatment to the treating therapist or supervision therapist at the facility. I further understand it is my responsibility to understand upon conclusion of the evaluation appointment I should understand the indications and contraindications for treatment and should notify the evaluating therapist if I do not understand. This consent shall remain in effect through the course of treatment unless revoked in writing.

Printed Name of Parent or Legal Guardian: _____

Address:_____ Phone: _____

Signature of Parent or Legal Guardian: _____

Witness:_____Date: _____