



PATIENT INFORMATION	EMAIL ADDRESS:
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First Name:	Last Name:	Middle Initial:	Date: / /
Address:		City:	State: Zip:
Birth date: / /	Age: <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other	S.S. #: - -
Home Phone: () -	Cell Phone () -	Spouse's Name:	

WORK INFORMATION

Employer:	Work Phone ()	Occupation:
Employer Address:		City: State: Zip:
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed <input type="checkbox"/> Full-time Student <input type="checkbox"/> Part-time Student		

REFERRAL/PHYSICIAN INFORMATION

Chose clinic because: <input type="checkbox"/> Former Patient <input type="checkbox"/> Close to Work/Home <input type="checkbox"/> Website <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Street Sign <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Family/Friend	
Referring Dr:	Referring Dr. Phone: () -
Regular Dr./PCP	Regular Dr./PCP Phone: () -

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)
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Primary Insurance Name:	
Subscriber's Name (If different):	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:	
Name of Secondary Insurance:	
Subscriber's Name:	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:	

AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACK UP)
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Insurance Name: <input type="checkbox"/> Auto : <input type="checkbox"/> Labor & Industries:	
Adjuster/Claim Manager:	Phone: Ext.:
Address:	City: State: Zip:
Claim #:	Accident Date: / / Cause:

ATTORNEY INFORMATION

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: () -

I authorize my insurance benefits be paid directly to Sportho Physical Therapy, Ltd.. I understand that I am financially responsible for any balance. I also authorize Sportho Physical Therapy, Ltd. to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE

DATE

PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE			JOINT CONDITIONS		
	YES	NO		YES	NO
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
Normal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremity Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE			OTHER CONDITIONS		
	YES	NO		YES	NO
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerotic Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
MUSCLE/TENDON CONDITIONS			CANCER (previous or currently)		
	YES	NO		YES	NO
Carpal Tunnel R/L	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Golfer's/Tennis Elbow R/L	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Back/Neck	<input type="checkbox"/>	<input type="checkbox"/>	Poor Eyesight	<input type="checkbox"/>	<input type="checkbox"/>
Hip/Knee/Ankle	<input type="checkbox"/>	<input type="checkbox"/>	CANCER (previous or currently)	<input type="checkbox"/>	<input type="checkbox"/>
Limited Limb Movement	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
LUNGS			_____		
	YES	NO	_____		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>			
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>			

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Low	<input type="checkbox"/> Smoking	Packs a Day _____
<input type="checkbox"/> 1-2 x Week	<input type="checkbox"/> Standing	<input type="checkbox"/> Medium	<input type="checkbox"/> Alcohol	Drinks a Week _____
<input type="checkbox"/> 3-4 x Week	<input type="checkbox"/> Light Labor	<input type="checkbox"/> High	<input type="checkbox"/> Coffee/Soda	Cups a Week _____
<input type="checkbox"/> 5+ x Week	<input type="checkbox"/> Heavy Labor			

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 in the past two years (Including 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 _____

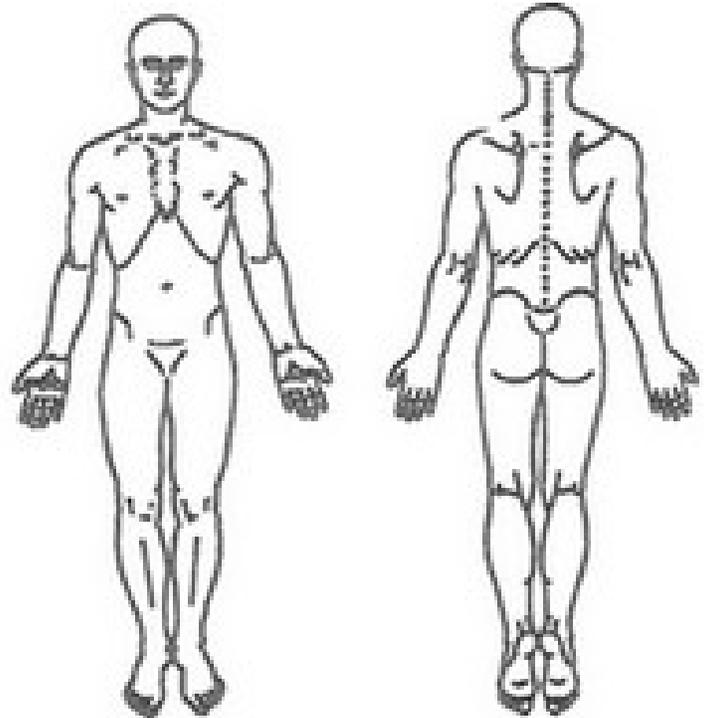
Date _____

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.

<u>Ache</u>	<u>Burning</u>	<u>Numbness</u>
MMM	-----	0 0 0 0
MM	-----	0 0 0
<u>Pins and Needles</u>	<u>Stabbing</u>	<u>Other</u>
pppp	////////	xxxx
ppp	////	xxx



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 AVERAGE 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 WORST level of pain:

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