

Patient Information Form

- Please Print -

PATIENT NAME _____ DATE OF FIRST VISIT _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____ PHONE (____) ____ - _____

WORK PHONE (____) ____ - _____ SEX M F S.S.# ____ - ____ - _____

DATE OF INJURY _____ AGE _____ DATE OF BIRTH _____

CURRENT DRIVERS LICENSE# _____ (MANDATORY)

EMERGENCY CONTACT NAME _____ PHONE (____) ____ - _____

RELATIONSHIP TO PATIENT _____

DOCTOR THAT REFERRED YOU FOR PHYSICAL THERAPY _____

PHYSICIAN PHONE (____) ____ - _____

OTHER SOURCE OF REFERRAL? _____

IS IT OK TO ACKNOWLEDGE THEM? YES NO

• • • • • • • • • • • • • • • •

PERSON RESPONSIBLE FOR PAYMENT (IF DIFFERENT FROM PATIENT)

FIRST NAME _____ OCCUPATION _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____ S.S.# ____ - ____ - _____

PHONE (____) ____ - _____ RELATIONSHIP TO INSURED? _____

• • • • • • • • • • • • • • • •

EMPLOYMENT INFORMATION (IF RETIRED/UNEMPLOYED PLEASE INDICATE LAST EMPLOYER)

EMPLOYER NAME _____ OCCUPATION _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____ PHONE (____) ____ - _____

SUPERVISOR'S NAME _____

INSURANCE INFORMATION

NAME OF PATIENT: _____ **TODAY'S DATE** _____

PRIMARY INSURANCE CARRIER: _____

ADDRESS _____ CITY _____ ZIP _____

MEMBER ID # _____

SECONDARY INSURANCE CARRIER: _____

ADDRESS _____ CITY _____ ZIP _____

MEMBER ID # _____

INJURY: YES / NO **IF YES:** AUTO WORK HOME OTHER

IF OTHER, PLEASE EXPLAIN _____

IS THERE LEGAL ACTION PENDING? YES NO

ATTORNEY'S NAME: _____

ADDRESS: _____ **CITY** _____ **ZIP** _____

TELEPHONE # (____) _____ **FAX #** (____) _____

WORKERS COMPENSATION CARRIER: _____

CLAIM NUMBER: _____

NAME OF ADJUSTER: _____

TELEPHONE # (____) _____ **FAX #** (____) _____

Huntington Beach Physical Therapy Specialists

History and Physical Condition Information

Name: _____ Age: _____

Referring Physician: _____ Today's Date: _____

Primary Care Physician: _____ Phone: _____

Problems to be treated: _____

Have you had treatment for this problem before? YES NO

If YES, state where: _____ When: _____

Treatment given:

Have you had surgery associated with this problem? YES NO

If YES, please list all medications: _____

Do you now have / or have you ever had any of the following:

High Blood Pressure	YES	NO	Sensitive to Heat/Ice	YES	NO
Heart Disease	YES	NO	Allergies	YES	NO
Heart Attack	YES	NO	Hernia	YES	NO
Pacemaker	YES	NO	Seizures	YES	NO
Diabetes	YES	NO	Metal Implants	YES	NO
Headaches	YES	NO	Dizzy Spells	YES	NO
Kidney Problems	YES	NO	Balance Problems	YES	NO
Nervous Disorder	YES	NO	Vision Problems	YES	NO
Hearing Problems	YES	NO	Other Illnesses	YES	NO
Cancer	YES	NO	Describe: _____		

If YES on any of the above, please explain and give approximate dates: _____

Have you had Physical Therapy before? YES NO If YES, when and for how long? _____

Are you pregnant? YES NO

List any other major illness or surgery that has occurred in the past year: _____

The above information is correct to the best of my knowledge.

Signature: _____ Date: _____

PAIN EVALUATION

Patient Name: _____

NUMERIC PAIN SCALE

PLEASE RATE YOUR PAIN ON THE FOLLOWING NUMERIC SCALE, BY CIRCLING THE NUMBER WHICH BEST DESCRIBES YOUR PAIN.

0	1	2	3	4	5	6	7	8	9	10
Normal No Pain	Very Weak	Weak	Moderate	Somewhat Strong	Strong		Very Strong		Very Very Strong	Emergency

THE PAIN DRAWING

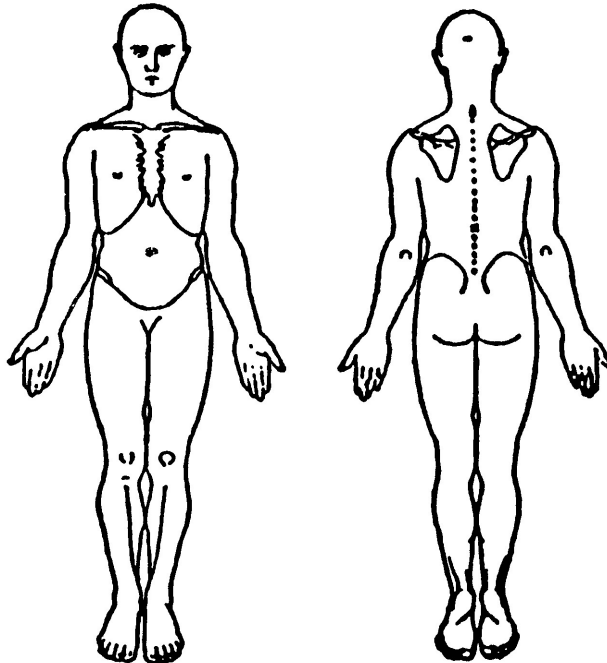
Indicate your symptoms on the body diagrams using symbols in the key.

OVERALL PAIN RATING

Pain As Bad
As It Can Be

No Pain At All

Place a Mark on this
line to describe
your pain.



KEY

//// Stabbing XXX Ache 000 Pins & Needles ===== Numbness

Patient's Signature: _____

Huntington Beach Physical Therapy Specialists

Consent Form

Patient Name: _____

Person to Contact in Case of Emergency:

Name: _____

Phone: _____

Authorization and Statement of Responsibility:

The undersigned agrees, whether signing as agent or patient, and is hereby individually obligated to pay for services rendered to the patient in accordance with the regular rates and terms of the company which are not reimbursed by third parties. The undersigned further agrees to bear legal fees and collection expenses which may be incurred by the company in collection of payment on the amount if it becomes delinquent.

Assignment of Benefits:

The undersigned hereby authorizes treatment by Huntington Beach Physical Therapy Specialists and assigns to Huntington Beach Physical Therapy Specialists any and all benefits arising out of any type of insurance which insures the patient's bill. The undersigned understands that the temporary acceptance of verified insurance coverage in lieu of payment does not release the patient from ultimate payment responsibility.

Release of Information:

The undersigned hereby authorizes Huntington Beach Physical Therapy Specialists to release any or all information to third parties, including but not limited to employers and insurance companies, who may be liable to the patient or Huntington Beach Physical Therapy Specialists for payment of charges to the patient.

Signature of Patient/Responsible Party Date

Incontinence Patient Form (if applicable)

How frequently do you urinate in a 24 hour period? _____

How many incontinent voids (accident) in a 24 hour period? _____

How much urine loss occurs with and incontinent void? _____
(Estimate: Small / Large)

Do you experience urine loss before reaching the toilet? _____

How often? _____

Do you leak urine when you (Please circle YES or NO):

Cough once? YES NO

Have coughing spells? YES NO

Sneeze once? YES NO

Have a sneezing spell? YES NO

Laugh? YES NO

Jump? YES NO

Run? YES NO

Walk? YES NO

Bend over? YES NO

Exercise? YES NO

Pick up an object YES NO

If YES, only when object is 5-15 lbs? YES NO Over 20 lbs? YES NO

Other? _____

When does urine loss most occur (circle one) DAY NIGHT BOTH

How much fluid do you drink during the day? _____

Do you drink caffeinated coffee, teas or sodas? _____

Amount & Frequency _____

What is the date of your last menses? _____

Have you ever been given hormone replacement therapy? (Date) _____

Are you undergoing hormone replacement now? _____

Do you use panty liners, sanitary napkins, tissues, disposable briefs, or any other absorbent material for urine control? _____

Do you leak urine when you are nervous or excited? YES NO

Does urine escape from you when you raise or lower yourself from a chair? YES NO

Is it difficult to stop urine once it starts flowing? YES NO

Are you currently taking any medications? YES NO

If YES, please list all medications: _____

Have you had any previous surgeries? YES NO

If YES, please list date and type of surgery: _____

Do you have or had any of the following:

High Blood Pressure	YES	NO	Allergies	YES	NO
Heart Attack	YES	NO	Hernia	YES	NO
Pacemaker	YES	NO	Seizures	YES	NO
Diabetes	YES	NO	Metal Implants	YES	NO
Headaches	YES	NO	Balance Problems	YES	NO
Nervous Disorder	YES	NO	Vision Problems	YES	NO
Hearing Problems	YES	NO	Arthritis	YES	NO
Pain In/Around Joints	YES	NO	Cancer	YES	NO
Kidney Problems	YES	NO	Other	YES	NO

If YES on any of the above, please explain and give approximate dates: _____

Name (Please Print): _____

Signature: _____ Date: _____

Confidence – Baseline

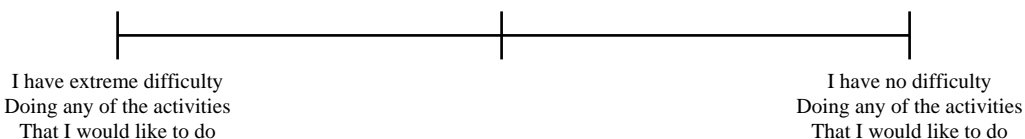
Instructions: Please circle the level of confidence you have for each activity today.	Fully confident in my ability to perform	Very confident	Moderately confident	Some confidence	Not confident in my ability to perform	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving—lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking—short distance	1	2	3	4	5	9
10. Walking—long distance	1	2	3	4	5	9
11. Walking—outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

OPTIMAL INSTRUMENT

Difficulty – Baseline

Instructions: Please circle the level of difficulty you have for each activity today.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving—lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking—short distance	1	2	3	4	5	9
10. Walking—long distance	1	2	3	4	5	9
11. Walking—outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking about all of the activities you would like to do, please mark an “X” at the point on the line that best describes your overall level of difficulty with these activities today.



23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for explain, if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose 1. 12 2. 8 3. 13)

1. ___ 2. ___ 3. ___

MEDICARE PATIENTS

PATIENT NAME _____

DATE _____

Due to new changes implemented by Medicare and CMS, we are asking you to please list all the medications, supplements, vitamins, and herbals that you currently take, along with their respective dosages, frequency and purpose. These new regulations have been implemented in an effort to improve quality care and reporting for all Medicare patients. Many medications and vitamins can affect your musuloskeletal system and informing us of them will help ensure the best possible treatment for you and your overall health. Thank you.

	Name of Medication/Vitamins/Supplements	Dosage/Frequency	Purpose of Medication
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			

Huntington Beach Physical Therapy Specialists
18800 Main Street #208
Huntington Beach, CA 92648
P: (714)841-6162 F: (714)841-9912

Huntington Beach Physical Therapy Specialists
18800 Main Street, Ste. 208 Huntington Beach, CA 92648 * 714-841-6162

Appointment & Cancellation Policy

Scheduling

In order to secure times that you desire, we recommend that you schedule at least two weeks of appointments, or up to the length of your prescription.

Cancellation Policy

- Please give 24 hours notice if you are unable to make your scheduled appointment. A \$35 fee will be incurred for any cancellations given without 24 hours notice.
- After two failed appointments without notification, your remaining appointments will be taken off the schedule until you notify us by telephone or in person.

I HAVE READ AND AGREE TO THE ABOVE APPOINTMENT & CANCELLATION POLICY.

Print Name

Patient's Signature

Date