

# Patient Information Form

-Please Print-

PATIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_ SEX: M F AGE: \_\_\_\_\_

IS IT OKAY TO LEAVE A MESSAGE ON THE PHONE NUMBER YOU PROVIDED? YES NO

DRIVERS LICENSE # \_\_\_\_\_ HOW DID YOU HEAR OF US? \_\_\_\_\_

REFERRING PHYSICIAN \_\_\_\_\_ PHYSICIAN'S PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

EMERGENCY CONTACT'S PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_

PRIMARY INSURANCE \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_

PERSON RESPONSIBLE FOR PAYMENT (IF DIFFERENT FROM PATIENT)

FULL NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

EMPLOYER NAME \_\_\_\_\_ EMPLOYER PHONE # \_\_\_\_\_

HAVE YOU HAD PREVIOUS PHYSICAL THERAPY, OCCUPATIONAL THERAPY, OR SPEECH THERAPY THIS CALENDAR YEAR? YES NO HAVE YOU HAD HOME HEALTH THERAPY? IF SO, WHEN? \_\_\_\_\_

PLEASE CHECK THE CAUSE OF INJURY RELATED TO THIS APPOINTMENT (MUST PICK ONE)

AUTO  WORK  HOME  OTHER (PLEASE EXPLAIN) \_\_\_\_\_

IF YOU CHECKED AUTO OR WORK ABOVE, PLEASE COMPLETE THE FOLLOWING:

IS THERE LEGAL ACTION PENDING? YES NO

ATTORNEY'S NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

WORKER'S COMPENSATION CARRIER \_\_\_\_\_ CLAIM NUMBER \_\_\_\_\_

NAME OF ADJUSTER \_\_\_\_\_ PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_



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# History and Physical Condition Information

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Problems to be treated: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Approximately when did your injury start? \_\_\_\_\_  
\_\_\_\_\_

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

What is your current height: \_\_\_\_\_ current weight: \_\_\_\_\_

Please list *all* medications on the separate *Medication list* form:

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 _____		
History of Smoking	YES	NO	Are you pregnant?	YES	NO

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

Have you had Physical Therapy before for any injury? YES NO If YES, when and for how long? \_\_\_\_\_

Please provide your intended goals for Physical Therapy involving your current injury. \_\_\_\_\_  
\_\_\_\_\_

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Pain Scale

Required for all Patients

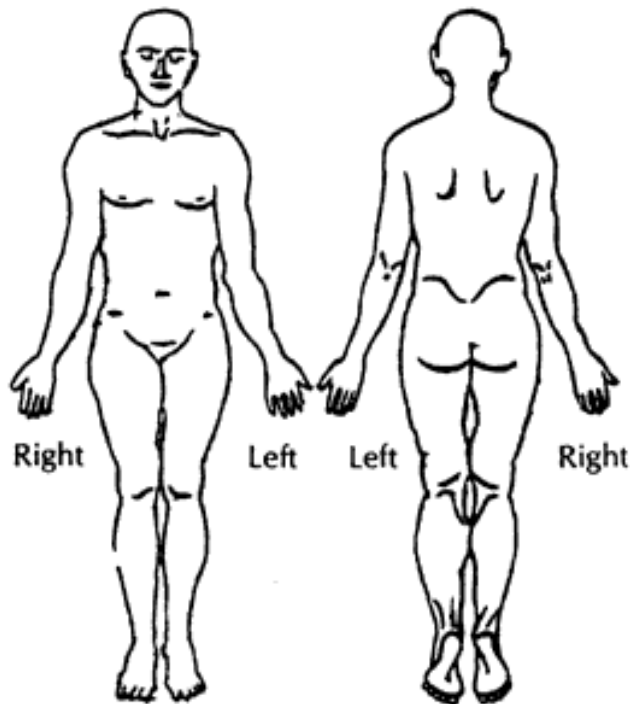
## NUMERIC PAIN SCALE

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	Emergency

## THE PAIN DRAWING

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



//// Stabbing

xxxx Aching

00000 Pins and needles

#### Numbness

X \_\_\_\_\_  
Patient Signature



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# Fall Efficacy Scale

(Required for all Medicare patients only)

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

*Pursuant to Medicare guidelines we are required to assess any risk for falls and provide an appropriate plan of care or advice for assistive device.*

1. Have you had two or more falls in the past year?    Yes    No  
If YES, when? \_\_\_\_\_
2. Were there any injuries caused by these falls?    Yes    No  
If YES, in what area? \_\_\_\_\_

On a scale from 1 to 10, with 1 being very confident and 10 being not confident at all, how confident are you that you do the following activities without falling?

Take a bath or shower

(Very Confident)    1    2    3    4    5    6    7    8    9    10    (Not at all Confident)

Reach into cabinets or closets

(Very Confident)    1    2    3    4    5    6    7    8    9    10    (Not at all Confident)

Walk around the house

(Very Confident)    1    2    3    4    5    6    7    8    9    10    (Not at all Confident)

Prepare meals not requiring carrying heavy or hot objects

(Very Confident)    1    2    3    4    5    6    7    8    9    10    (Not at all Confident)

Get in and out of bed

(Very Confident)    1    2    3    4    5    6    7    8    9    10    (Not at all Confident)

Answer the door or telephone

(Very Confident)    1    2    3    4    5    6    7    8    9    10    (Not at all Confident)

Get in and out of a chair

(Very Confident)    1    2    3    4    5    6    7    8    9    10    (Not at all Confident)

Getting dressed and undressed

(Very Confident)    1    2    3    4    5    6    7    8    9    10    (Not at all Confident)

Personal grooming (i.e. washing your face)

(Very Confident)    1    2    3    4    5    6    7    8    9    10    (Not at all Confident)

Getting on and off of the toilet

(Very Confident)    1    2    3    4    5    6    7    8    9    10    (Not at all Confident)



# Consent Form

Patient Name: \_\_\_\_\_ If minor, parent/guardian name \_\_\_\_\_

A photocopy of this document and signatures shall be considered as effective and valid as the original.

1. CONSENT FOR TREATMENT: I, the undersigned, hereby authorize Huntington Beach Physical Therapy Specialists and/or Tustin Physical Therapy Specialists (the "Clinic") to render services to me/patient, which are deemed necessary by the treating provider.

X

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

2. RESPONSIBILITY FOR PAYMENT: I, the undersigned, take full responsibility for payments for all services rendered by Provider. If I have insurance benefits available, I understand that my insurance is a contract between me and my insurance company and NOT between the provider and my insurance company, and that I will be solely responsible for all billing and collection from the insurance company for all services rendered. The Provider cannot guarantee that the insurance company will pay, even if the policy provides for coverage, or approval was previously granted. Payment is due when services are rendered unless previous arrangements have been provided.

X

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

3. CONFIDENTIALITY & PRIVACY OF PATIENT: I am aware that my medical information is confidential and may not be shared (except as permitted by law) with anybody without my consent. I am also aware that the staff at the Clinic may view my medical records for continuity of treatment.

X

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

4. AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I have read and fully understand the Clinic's Notice of Information Practices, the undersigned, consent to the use and disclosure of my personal health information for purposes as noted in the Clinic's Notice of Information and hereby authorizes the Provider and Staff to release information concerning my health acquired in the course of examination, history and treatment to a Physician, Healthcare provider and/or Insurance Carrier, as appropriate.

X

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

5. 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.**

X

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

6. SCHEDULING: In order to secure times that you desire, we recommend that you schedule at least two weeks of appointments, up to the length of your prescription, but it remains your choice to schedule future appointments and your responsibility to continue to schedule for the duration of your treatment.

Please initial here \_\_\_\_\_



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# Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Unbearable pain

Name \_\_\_\_\_ Date \_\_\_\_\_

**Instructions:** Please circle the **ONE NUMBER** in each section which most closely describes your problem.

## Section 1 – Pain Intensity

0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

## Section 2 – Personal Care (Washing, Dressing, etc.)

0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

## Section 3 – Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

## Section 4 – Walking

0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

## Section 5 – Sitting

0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

## Section 6 – Standing

0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

## Section 7 – Sleeping

0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

## Section 8 – Social Life

0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

## Section 9 – Traveling

0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

## Section 10 – Changing Degree of Pain

0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TOTAL \_\_\_\_\_