

# Patient Information Form

-Please Print-

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

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

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

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

HOW DID YOU HEAR OF US? \_\_\_\_\_

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

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

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

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

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

DO YOU NEED A TRANSLATOR? YES NO Would you like one provided? Yes No WHICH LANGUAGE: \_\_\_\_\_

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? \_\_\_\_\_

DO YOU HAVE AN ADVANCED DIRECTIVE? YES NO DO YOU NEED INFORMATION ON ONE? YES NO

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 ( ) \_\_\_\_\_ - \_\_\_\_\_



HUNTINGTON BEACH  
PHYSICAL THERAPY  
**SPECIALISTS**

(714) 841-6162

www.HBPTS.com

# 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: \_\_\_\_\_



HUNTINGTON BEACH  
PHYSICAL THERAPY  
SPECIALISTS

[www.HBPTS.com](http://www.HBPTS.com)  
714.841.6162

19582 Beach Blvd. Suite 130  
Huntington Beach, CA 92648

# Medication List

*Required for all patients*

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

| Name of Medication/Vitamins/Supplements | Dosage/Frequency | Purpose of Medication |
|-----------------------------------------|------------------|-----------------------|
|                                         |                  |                       |
|                                         |                  |                       |
|                                         |                  |                       |
|                                         |                  |                       |
|                                         |                  |                       |
|                                         |                  |                       |
|                                         |                  |                       |
|                                         |                  |                       |
|                                         |                  |                       |
|                                         |                  |                       |
|                                         |                  |                       |
|                                         |                  |                       |
|                                         |                  |                       |
|                                         |                  |                       |
|                                         |                  |                       |
|                                         |                  |                       |
|                                         |                  |                       |
|                                         |                  |                       |
|                                         |                  |                       |
|                                         |                  |                       |
|                                         |                  |                       |
|                                         |                  |                       |
|                                         |                  |                       |
|                                         |                  |                       |
|                                         |                  |                       |

*(Attn: Medicare Patients: Due to new changes implemented by Medicare and CMS, we are asking you to please list all the medications, supplements, vitamins, and herbs 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 musculoskeletal system and informing us of them will help ensure the best possible treatment for you and your overall health.)*



**www.HBPTS.com**  
**19582 Beach Blvd. Ste130**  
**Huntington Beach, CA 92648**  
**714.841.6162**

# Pain Scale

Required for all Patients

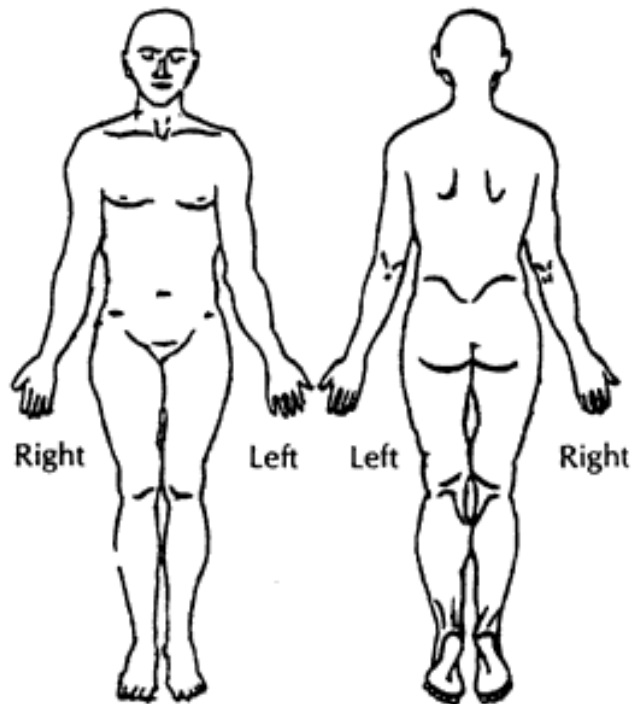
## NUMERIC PAIN SCALE

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<br>No Pain | Very<br>Weak | Weak | Moderate |   | Somewhat<br>Strong | Strong |   | Very<br>Strong | Very<br>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



[www.HBPTS.com](http://www.HBPTS.com)  
19582 Beach Blvd. Suite 130  
Huntington Beach, CA 92648  
714.841.6162

# 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 \$50 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.**

SCHEDULING: In order to secure times that you desire, we recommend you schedule follow up visits in advance. It remains your choice to schedule future appointments and your responsibility to continue to schedule for the duration of your treatment.

X

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

\_\_\_\_\_  
Date

6. **EMAIL:** Please keep in mind that communication via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.

Please initial here \_\_\_\_\_ Date: \_\_\_\_\_



HUNTINGTON BEACH  
PHYSICAL THERAPY  
SPECIALISTS

www.HBPTS.com

714.841.6162

# Headache Research Report

## APPENDIX M

### Constipation Scoring System

(Agachan et al., 1996)

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

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

#### Frequency of bowel movements

- 0 1-2 times per 1-2 days
- 1 2 times per week
- 2 Once per week
- 3 Less than once per week
- 4 Less than once per month

#### Difficulty: painful evacuation effort

- 0 Never
- 1 Rarely
- 2 Sometimes
- 3 Usually
- 4 Always

#### Completeness: feeling incomplete evacuation

- 0 Never
- 1 Rarely
- 2 Sometimes
- 3 Usually
- 4 Always

#### Pain: abdominal pain

- 0 Never
- 1 Rarely
- 2 Sometimes
- 3 Usually
- 4 Always

#### Time: minutes in lavatory per attempt

- 0 Less than 5
- 1 5-10
- 2 10-20
- 3 20-30
- 4 More than 30

#### Assistance: type of assistance

- 0 Without assistance
- 1 Stimulative laxatives
- 2 Digital assistance or enema

#### Failure: unsuccessful attempts for evacuation per 24 hours

- 0 Never
- 1 1-3
- 2 3-6
- 3 6-9
- 4 More than 9

#### History: duration of constipation (yr)

- 1 0
- 2 1-5
- 3 5-10
- 4 10-20
- 5 More than 20

TOTAL SCORE: \_\_\_\_\_

(Minimum Score, 0; Maximum Score, 30)