

# 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 \_\_\_\_\_

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



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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: \_\_\_\_\_



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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.)*



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# Pain Scale

Required for all Patients

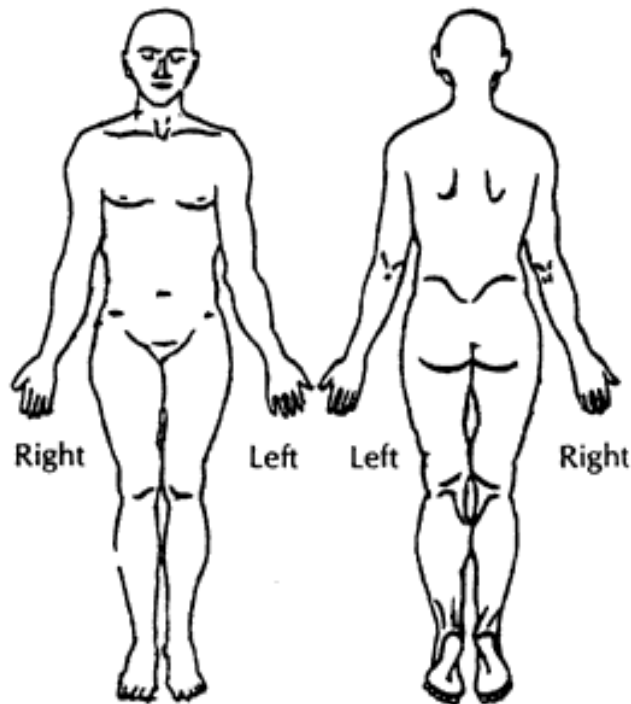
## NUMERIC PAIN SCALE

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 \$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: \_\_\_\_\_



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# OSWESTRY LOW BACK DISABILITY QUESTIONNAIRE

Instructions: this questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you at this time. We realize you may consider 2 of the statements in any section may relate to you, but please mark the box which most closely describes your current condition.

## 1. PAIN INTENSITY

- I can tolerate the pain I have without having to use pain killers
- The pain is bad but I manage without taking pain killers
- Pain killers give complete relief from pain
- Pain killers give moderate relief from pain
- Pain killers give very little relief from pain
- Pain killers have no effect on the pain and I do not use them

## 2. PERSONAL CARE (e.g. Washing, Dressing)

- I can look after myself normally without causing extra pain
- I can look after myself normally but it causes extra pain
- It is painful to look after myself and I am slow and careful
- I need some help but manage most of my personal care
- I need help every day in most aspects of self care
- I don't get dressed, I was with difficulty and stay in bed

## 3. LIFTING

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives extra pain
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- I can lift very light weights
- I cannot lift or carry anything at all

## 4. WALKING

- Pain does not prevent me walking any distance
- Pain prevents me walking more than one mile
- Pain prevents me walking more than ½ mile
- Pain prevents me walking more than ¼ mile
- I can only walk using a stick or crutches
- I am in bed most of the time and have to crawl to the toilet

## 5. SITTING

- I can sit in any chair as long as I like
- I can only sit in my favorite chair as long as I like
- Pain prevents me from sitting more than one hour
- Pain prevents me from sitting more than ½ hour
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting at all

## 6. STANDING

- I can stand as long as I want without extra pain
- I can stand as long as I want but it gives me extra pain
- Pain prevents me from standing for more than one hour
- Pain prevents me from standing for more than 30 minutes
- Pain prevents me from standing for more than 10 minutes
- Pain prevents me from standing at all

## 7. SLEEPING

- Pain does not prevent me from sleeping well
- I can sleep well only by using medication
- Even when I take medication, I have less than 6 hrs sleep
- Even when I take medication, I have less than 4 hrs sleep
- Even when I take medication, I have less than 2 hrs sleep
- Pain prevents me from sleeping at all

## 8. SOCIAL LIFE

- My social life is normal and gives me no extra pain
- My social life is normal but increases the degree of pain
- Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. dancing, etc.
- Pain has restricted my social life and I do not go out as often
- Pain has restricted my social life to my home
- I have no social life because of pain

## 9. TRAVELLING

- I can travel anywhere without extra pain
- I can travel anywhere but it gives me extra pain
- Pain is bad, but I manage journeys over 2 hours
- Pain restricts me to journeys of less than 1 hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from traveling except to the doctor or hospital

## 10. EMPLOYMENT/ HOME MAKING

- My normal homemaking/ job activities do not cause pain.
- My normal homemaking/ job activities increase my pain, but I can still perform all that is required of me.
- I can perform most of my homemaking/ job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming)
- Pain prevents me from doing anything but light duties.
- Pain prevents me from doing even light duties.
- Pain prevents me from performing any job or homemaking chores.