Patient Information Form

- Please Print -

PATIENT NAME_____DATE OF FIRST VISIT_____

ADDRESS_____CITY_____

STATE_____ZIP_____PHONE ( ) -_____

WORK PHONE (____)_____-_____ SEX: M F AGE_____ DATE OF BIRTH _____

DATE OF INJURY_____

CURRENT DRIVERS LICENSE#_____(MANDATORY)

DOCTOR THAT REFERRED YOU FOR PHYSICAL THERAPY _____

PHYSICIAN PHONE ( )_____- _____

WHO REFERRED YOU TO OUR CLINIC or HOW DID YOU HEAR OF US? _____

_____

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 _____

HUNTINGTON BEACH PHYSICAL THERAPY SPECIALISTS

www.HBPTS.com • 714.841.6162
19582 Beach Blvd. Suite 130
Huntington Beach, CA 92648

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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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

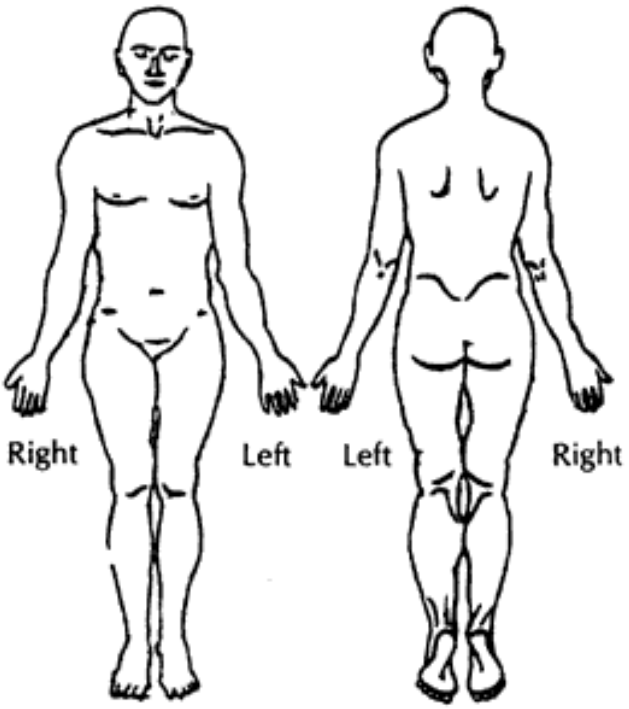
NUMERIC PAIN SCALE

PLEASE RATE YOUR PAIN ON THE FOLLOWING NUMBERIC 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)