Patient Information Form

-Please Print-

PATIENT NAME_____ DATE OF BIRTH_____

ADDRESS_____CITY_____SATE_____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

The Migraine Disability Assessment Test

The **MIDAS** (Migraine Disability Assessment) questionnaire was put together to help you measure the impact your headaches have on your life. The information on this questionnaire is also helpful for your primary care provider to determine the level of pain and disability caused by your headaches and to find the best treatment for you.

INSTRUCTIONS

Please answer the following questions about ALL of the headaches you have had over the last 3 months. Select your answer in the box next to each question. Select zero if you did not have the activity in the last 3 months. Please take the completed form to your healthcare professional.

_____ 1. On how many days in the last 3 months did you miss work or school because of your headaches?

_____ 2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school.)

_____ 3. On how many days in the last 3 months did you not do household work (such as housework, home repairs and maintenance, shopping, caring for children and relatives) because of your headaches?

_____ 4. How many days in the last 3 months was your productivity in household work reduced by half of more because of your headaches? (Do not include days you counted in question 3 where you did not do household work.)

_____ 5. On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches?

_____ Total (Questions 1-5)

What your Physician will need to know about your headache:

_____ A. On how many days in the last 3 months did you have a headache? (If a headache lasted more than 1 day, count each day.)

_____ B. On a scale of 0 - 10, on average how painful were these headaches? (where 0=no pain at all, and 10= pain as bad as it can be.)

Scoring: After you have filled out this questionnaire, add the total number of days from questions 1-5 (ignore A and B).

MIDAS Grade	Definition	MIDAS Score
I	Little or No Disability	0-5
II	Mild Disability	6-10
III	Moderate Disability	11-20
IV	Severe Disability	21+

If Your MIDAS Score is 6 or more, please discuss this with your doctor.

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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: _____

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

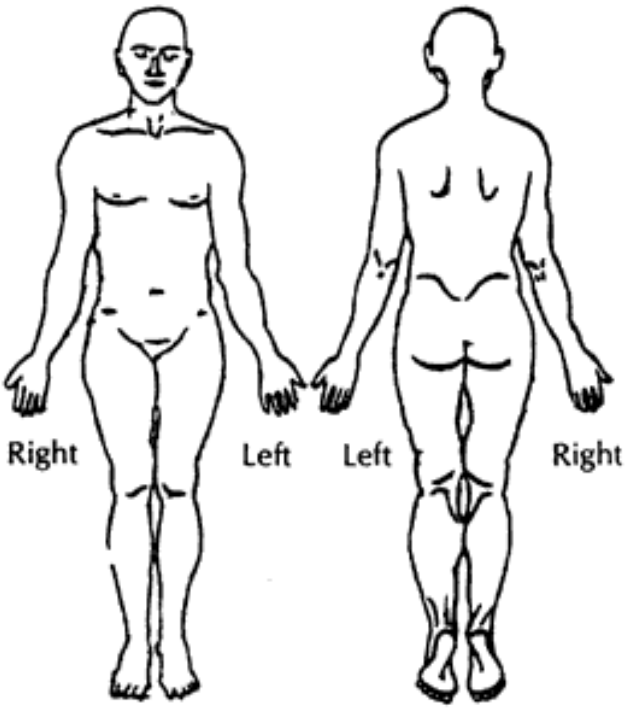
NUMERIC PAIN SCALE

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

HUNTINGTON BEACH PHYSICAL THERAPY SPECIALISTS

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)