

Maple Leaf Physical Therapy

PATIENT INFORMATION		EMAIL ADDRESS: _____		
First Name:	Last Name:	Middle Initial:	Date: / /	
Address:		City:	State:	Zip:
Birth date: / /	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female	S.S. #: - -	
Home Phone: () -		Alternative Phone (Cell, Pager): () -		Spouse:
Chose Clinic Because/ Referred to Clinic By <input type="checkbox"/> Dr.: <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Family <input type="checkbox"/> Friend				
<input type="checkbox"/> Former Patient <input type="checkbox"/> Close to Work/Home <input type="checkbox"/> Website <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Street Sign <input type="checkbox"/> Other:				
WORK INFORMATION				
Employer:		Work Phone ()	Ext.	
Occupation:	Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed			
CARE PROVIDER INFORMATION				
Referring Dr:		Referring Dr. Phone: () -		
Regular Dr./PCP		Regular Dr./PCP Phone: () -		
INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)				
Primary Insurance Name:				
Subscriber's Name (If different):			Birth date : / /	
ID. #:	Group/Policy #			
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:				
Name of Secondary Insurance:				
Subscriber's Name:			Birth date : / /	
ID. #:	Group/Policy #			
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:				

AUTO OR WORK INJURY CLAIM**(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)**Insurance Name: Auto : Labor & Industries:

Adjuster/Claim Manager:

Phone:

Ext.:

Address:

City

State:

Zip:

Claim #:

Accident Date: / /

Cause:

ATTORNEY INFORMATION

Name:

Law Firm:

Phone: () -

Address

City

State:

Zip:

IN CASE OF EMERGENCY

Name of Local Friend or Relative (Not Living at Same Address):

Relationship to Patient:

Home Phone: () -

Work Phone: () -

I authorize my insurance benefits be paid directly to Practice Name. I understand that I am financially responsible for any balance. I also authorize _____ to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE

DATE



PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE			JOINT CONDITIONS		
	YES	NO		YES	NO
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
Normal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremity Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE			OTHER CONDITIONS		
	YES	NO		YES	NO
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerotic Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
MUSCLE CONDITION			Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
	YES	NO	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Carpal Tunnel R/L	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Tennis Elbow R/L	<input type="checkbox"/>	<input type="checkbox"/>	Poor Eyesight	<input type="checkbox"/>	<input type="checkbox"/>
Back/Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Limited Limb Movement	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
LUNGS			Other: _____		
	YES	NO	_____		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	_____		

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Low	<input type="checkbox"/> Smoking	Packs a Day _____
<input type="checkbox"/> 1-2x/Week	<input type="checkbox"/> Standing	<input type="checkbox"/> Medium	<input type="checkbox"/> Alcohol	Drinks a Week _____
<input type="checkbox"/> 3-4x/Week	<input type="checkbox"/> Light Labor	<input type="checkbox"/> High	<input type="checkbox"/> Coffee/Soda	Cups a Week _____
<input type="checkbox"/> 5+ Week	<input type="checkbox"/> Heavy Labor			_____

What types of exercise do you perform? :

Are you taking any seizure medication? YES NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?
If yes list name: _____

List all surgeries in the past two years (Including dates): _____

Are you pregnant? YES NO What week?: _____

Have you had any injuries related to work? YES NO If yes list body part and date.: _____

Have you had any Auto Accidents YES NO If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? YES NO Where: _____

Signature of Patient, Parent, Guardian, Personal Representative

Date

Pain and Symptom Status Report

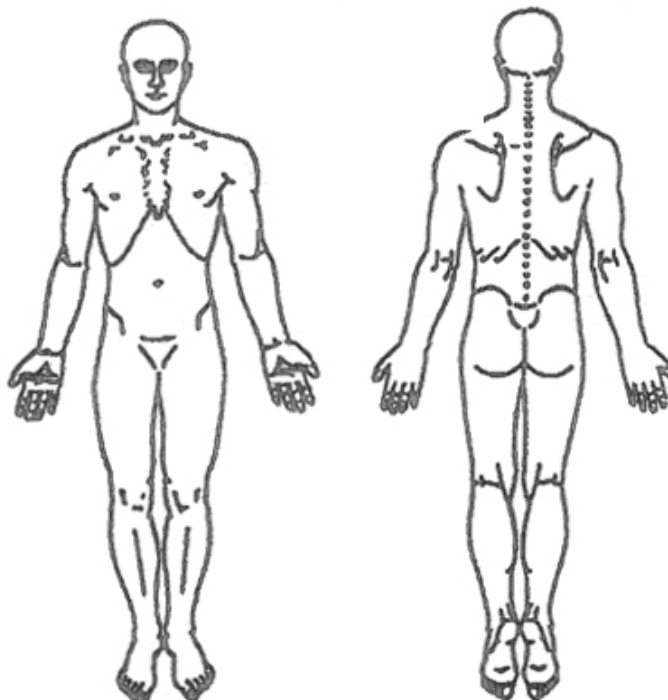
Name: _____

Date: _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing

- | | | |
|---|---|-------------------------------------|
| Ache
MMM
M | Burning

--- | Numbness
O O O O
O O O |
| Pins and Needles
□ □ □ □ □ □ □ □ □ □
□ □ □ □ □ □ □ □ □ □ | Stabbing
/ / / / / / / /
/ / / / | Other
x x x x
x x x |



Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____

Date First Symptom of your problem occurred on. _____

2nd Complaint _____

3rd Complaint: _____

Please circle on the scale below to indicate your <u>CURRENT</u> level of pain:												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it gets.
Please circle on the scale below to indicate your <u>AVERAGE</u> level of pain:												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it gets.
Please circle on the scale below to indicate your <u>WORST</u> level of pain:												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it gets.

Additional Comments _____