Patient Demographics

Name:* _____ **Date of Birth:*** _____ **Age:*** _____

Parents or Guardian(if minor): _____ **Gender:*** ○ Male ○ Female

Address:* _____ **Marital Status:*** ○ Single ○ Married ○ Divorced ○ Widowed

City:* _____ **State:*** _____ **Home Number:*** _____

Zip:* _____ **Cell Number:*** _____

Email:* _____ **Work Number:*** _____

Occupation:* _____ **Employer:*** _____

Referred to Clinic by or Chose clinic because (please select one box below):

☐ Dr. _____ ☐ Affiliation/Sponsorship _____

☐ Family ☐ Friend ☐ Close to home or work ☐ Google Reviews ☐ Insurance ☐ Other

If referred, whom we may thank?: _____

EMERGENCY CONTACT

Name:* _____ **Phone Number:*** _____

Relationship:* _____

INSURANCE:

☐ Is this a Motor Vehicle Accident? **Claim?:** ○ Yes ○ No

If Yes, Date: _____ **State:** _____

☐ Is this a Workman s Comp? **Claim?:** ○ Yes ○ No

If Yes, Date: _____ **State:** _____

Claim # (if work. comp. or MVA): _____

Primary Insurance: _____

ID#: _____

Address: _____

Phone: _____

Secondary Insurance: _____

ID#: _____

Address: _____

Phone: _____

History of Present Conditions

When did your symptoms begin?: _____

Are your symptoms: ○ Constant ○ Intermittent ○ Improving ○ Worsening ○ Unchanging ○ Activity Dependent

Did you have surgery: ○ Yes ○ No **If Yes, Date:** _____ **Type of Surgery:** _____

Have you experienced these same or similar symptoms prior to this episode?: ○ Yes ○ No **When?:** _____

How did your injury/issue start?:

What is your primary concern?:

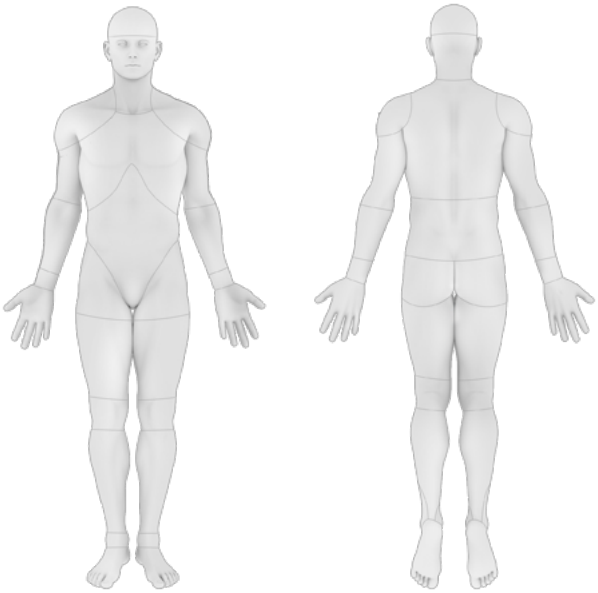
Have your received treatment for this before?: ○ Yes ○ No **Did it get better?:** ○ Yes ○ No

Where?: _____ **When?:** _____

Do your symptoms interrupt your sleep?: ○ Yes ○ No

When is your pain the worst?: ○ Morning ○ Night ○ At Rest ○ During Activy ○ After Activity

Pain Drawing



Pain Rating - please rate your pain in the scale below, circle the number that best represents your pain:

	Feel Great	Annoying	Nagging Pain	Hurts even more	Intense Horrible	Unbearable
Worst pain in the past 48 hours:	0	1	2	3	4	5	6	7	8	9	10
Current intensity of pain:	0	1	2	3	4	5	6	7	8	9	10
Best pain in the past 48 hours:	0	1	2	3	4	5	6	7	8	9	10

What makes your pain worse?:

What are you not doing well?:

What makes your pain better?:

What do you still do great?:

Patient Medical Screening Questionnaire

Do you smoke?: ○ Yes ○ No **Do you have a pacemaker?:** ○ Yes ○ No

Do you use a: ○ Cane ○ Walker ○ Wheelchair ○ Other _____

Women only: Are you currently pregnant or think you may be pregnant: ○ Yes ○ No

Past Medical History: **Please check all that apply, if none apply check here:** ☐

☐ Alzheimer s	☐ Diabetes	☐ Lupus	☐ Asthma
☐ Cardiovascular Disease	☐ Fibromylagia	☐ Osteoarthritis	☐ Dizziness/Fainting
☐ Cerebral Vascular Accident	☐ Fracture or Suspected Fracture	☐ Parkinson s	☐ Bowel/Bladder Abnormality
☐ Current Infection	☐ High Blood Pressure	☐ Headaches	
☐ Osteoporosis	☐ History of Cancer	☐ Rheumatoid Arthritis	
☐ Urine Leakage	☐ Immunosuppression	☐ Traumatic Brain Injury	

☐ Other: _____

Please list current medications, over the counter medication, vitamins, and supplements (include dosage and purpose):

What are your goals or things you want to get back to doing?:

Eagle Physical Therapy is committed to providing quality physical therapy at reasonable cost. It is our policy to collect all accounts receivable within 90 days from date of service.

For those patients with insurance coverage, we bill regularly.***However, the patient is responsible to understand the specifics of their individual insurance coverage.*** The insurance contract is between the covered individual and the insurance company. The patient retains ultimate responsibility for financial charges incurred as a result of treatment. Our staff is available for assistance with insurance billing questions.

☐ I hereby consent to such physical therapy procedures as may be rendered by Eagle Physical Therapy. There is also consent for authorization of all insurance benefits to be paid directly to Eagle Physical Therapy, and assumption of all financial responsibility for the balance of charges not included in the insurance coverage. A $25.00 fee will be charged for returned checks. Eagle Physical Therapy has the authority to disclose medical information for treatment, payment and health operations. Eagle Physical Therapy is released from disclosure of the patient s records as provided by this paragraph.*

☐ I acknowledge that I have been informed and notified of the whereabouts of Eagle Physical Therapy s notice of information practices (how medical information regarding myself may be used and disclosed and how I can get access to this information):*

☐ I understand the receiving physical therapy care does involve treatment in an open area, there by not providing full privacy at all times. If you feel uncomfortable with discussing your medical history, current problem, or plan of care in an open area, please notify your therapist before the assessment begins and accommodations will be made.*

Patient/Guardian s Signature:* _____ **Date:*** _____