PERSONAL IDENTIFICATION INFORMATION

Odessa·Physical·Therapy

Name:	Home Phone:		Cell Phone:
Street Address:	Mailing Address:		
City, State, ZIP:	Birth Date:	Age:	Sex:
Social Security Number:	Occupation:		
Employer:	Employer Phone:		
If married, Spouse's Name:	Spouse's Cell Phone:		
Spouse's Employer:	Spouse's Employer Phone:		
If minor, Guardian's Name:	Guardian's Cell Phone:		
Guardian's Employer:	Guardian's Employer Phone:		
Referring Physician:	Referring Physician's Phone:		
Primary Care Physician:	Primary Care Physician's Phone:		
Emergency Contact:	Emergency Contact Phone:		

Did this injury happen on the job?	☐ Yes	☐ No
Are you claiming Workers' Compensation?	☐ Yes	☐ No
Have you notified your employer?	☐ Yes	☐ No

WORKERS' COMP INSURANCE CARRIER:		
Adjuster:	Claim Number:	
Employer (at time of injury):	Employer Phone:	
Employer Address:	Nurse Case Manager (If applicable):	
PRIMARY INSURANCE CARRIER:		
Insured's Name:	Employer:	
Insured's SSN:	D.O.B.:	Relationship:
SECONDARY INSURANCE CARRIER:		
Insured's Name:	Employer:	
Insured's SSN:	D.O.B.:	Relationship:

PAST MEDICAL HISTORY FORM

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PATIENT NAME:

BLOOD PRESSURE	YES	NO
Hypertension (High Blood Pressure)	☐	☐
Low Blood Pressure	☐	☐
HEART DISEASE	**YES**	**NO**
Atherosclerotic Disease	☐	☐
Heart Murmur	☐	☐
Myocardial Infarction (Heart Attack)	☐	☐
Rheumatic Heart Disease	☐	☐
MUSCLE CONDITION	**YES**	**NO**
Back/ Neck Problems	☐	☐
Carpal Tunnel Left Right	☐	☐
Limited Limb Movement	☐	☐
Tennis Elbow Left Right	☐	☐
LUNGS	**YES**	**NO**
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐
DO YOU HAVE ANY IMPLANTABLE DEVICE?		
Pacemaker	☐	☐
Pain Stimulator	☐	☐

JOINT CONDITIONS	YES	NO
Osteoarthritis	☐	☐
Osteoporosis	☐	☐
Rheumatoid Arthritis	☐	☐
OTHER CONDITIONS	**YES**	**NO**
Diabetes	☐	☐
Epilepsy	☐	☐
Fibromyalgia	☐	☐
Hearing Loss	☐	☐
Mental Heath	☐	☐
Multiple Sclerosis	☐	☐
Muscular Dystrophy	☐	☐
Polio	☐	☐
Poor Eyesight	☐	☐
Reynaud's Disease	☐	☐
Seizure Disorder/Medication	☐	☐

Other devices:

EXERCISE		WORK ACTIVITY		STRESS LEVEL		HABITS		
☐	None	☐	Sitting	☐	Low	☐	Alcohol	Drinks a week?
☐	1-2x Week	☐	Standing	☐	Medium	☐	Coffee/Soda	Cups a week?
☐	3-4x Week	☐	Light Labor	☐	High	☐	Smoking	Packs per day?
☐	S+x Week	☐	Heavy Labor					How many years?

What type of exercise do you perform?

What things cause stress in your life?

PAST MEDICAL HISTORY

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PATIENT NAME:					
Do you have any physical restrictions placed upon you by your doctor?		□ **YES**	□ **NO**		
If yes, please explain:					
How would you rate your overall health?	**POOR**	**FAIR**	**GOOD**	**VERY GOOD**	**EXCELLENT**
Are you currently receiving home health?	□ **YES**	□ **NO**			
List all major surgeries including dates:					
Are you pregnant?	□ **YES**	□ **NO**	*If yes, due date:*		
Have you had any work-related injuries?	□ **YES**	□ **NO**	*If yes, list body part & date:*		
Have you had any injuries from a moving vehicle accident?		□ **YES**	□ **NO**	*List body part & date:*	
Have you had physical/occupational therapy before?		□ **YES**	□ **NO**	*List body part & date:*	

Signature of Patient or Guardian Date

PAIN AND SYMPTOM STATUS REPORT

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PATIENT NAME: _____ **DATE:** ___/___/_____

Describe how your injury occurred: _____

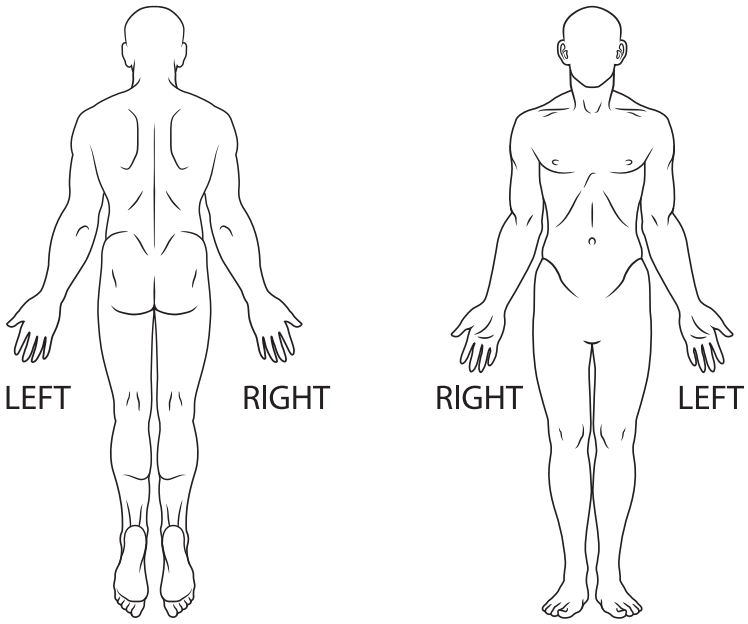
_____

_____

Date of Injury: _____

Using the symbols below, please draw the type of pain you are experiencing in the appropriate location.

ACHE M	**BURNING** -	**NUMBNESS** x
PINS D	**STABBING** /	**OTHER** 0



My chief complaint is:

Date when symptoms first occurred:

2nd Complaint:

3rd Complaint:

0 - being no pain and 10 - being worst pain

My pain at its best is:	0	1	2	3	4	5	6	7	8	9	10
My pain at its worst is:	0	1	2	3	4	5	6	7	8	9	10
My current pain level:	0	1	2	3	4	5	6	7	8	9	10
My Average pain level:	0	1	2	3	4	5	6	7	8	9	10

LIST OF MEDICATIONS

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Name: _____ **Date:** ____/____/_____

Please list all the medication that you currently take. Please include prescription, over the counter, herbals, vitamins/minerals, and nutritional supplements. Please include dosage, frequency, and how the medication is administered (oral, injection, etc.)

Medication Name	**Dosage** (mg, cc, etc.)	**Frequency** (Ix/day, etc.)	**Administered** (by oral, injection, etc.)

Medical Information Release Form

(HIPAA Release Form)

Name:_____ Date of Birth: ____/____/_____

Release of Information
□ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be release to: □ Spouse_____ □ Child (ren)_____ □ Other _____ □ Information is not to be released to anyone. This ***Release of Information*** will remain in effect until terminated by me in writing,

Messages
Please call □ my home □ my work □ my cell number:_____ □ If unable to reach me: □ you may leave a detailed message □ please leave a message asking me to return your call □ _____ The best time to reach me is (day)_____between (time)_____

Signed:_____Date:____/____/____

Witness:_____Date:____/____/____