Odessa · Physical · Therapy

PERSONAL IDENTIFICATION INFORMATION

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 Physicians 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:

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PAST MEDICAL HISTORY FORM

PATIENT NAME:

BLOOD PRESSURE	YES	NO	JOINT CONDITIONS	YES	NO
Hypertension (High Blood Pressure)	☐	☐	Joint Replacements (*list below*)	☐	☐
Low Blood Pressure	☐	☐			
HEART DISEASE	**YES**	**NO**			
Atherosclerotic Disease	☐	☐			
Heart Murmur	☐	☐	Osteoarthritis	☐	☐
Myocardial Infarction (Heart Attack)	☐	☐	Osteoporosis	☐	☐
Rheumatic Heart Disease	☐	☐	Rheumatoid Arthritis	☐	☐
MUSCLE CONDITION	**YES**	**NO**	**OTHER CONDITIONS**	**YES**	**NO**
Back/ Neck Problems	☐	☐	Diabetes	☐	☐
Carpal Tunnel Right Left	☐	☐	Epilepsy	☐	☐
Limited Limb Movement	☐	☐	Fibromyalgia	☐	☐
Tennis Elbow Right Left	☐	☐	Hearing Loss	☐	☐
LUNGS	**YES**	**NO**	Mental Heath	☐	☐
Asthma	☐	☐	Multiple Sclerosis	☐	☐
Emphysema	☐	☐	Muscular Dystrophy	☐	☐
Shortness of Breath	☐	☐	Polio	☐	☐
DO YOU HAVE ANY IMPLANTABLE DEVICE?			Poor Eyesight	☐	☐
Pacemaker/ Defibrillator	☐	☐	Reynaud's Disease	☐	☐
Pain Stimulator	☐	☐	Seizure Disorder	☐	☐
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 a day?
☐ 5+x Week	☐ Heavy Labor			How many years?
What type of exercise do you preform?				
What things cause stress in your life?				

How did you hear about us?

☐ Doctor ☐ Family Member ☐ Friend ☐ Google Search ☐ Other

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PAST MEDICAL HISTORY

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**			
Are you currently taking any medications? *(list below)*	☐ **YES**	☐ **NO**			
Are you currently taking any medications that might affect your lungs, heart, consciousness, or general well-being while participating in therapy?	☐ **YES**	☐ **NO**			
If yes, list any medications:					
List all surgeries in the past two years, including dates:					
Are you pregnant?	☐ **YES**	☐ **NO**			
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**	*If yes, list body part &*		
date:					
Have you had physical/occupational therapy before?	☐ **YES**	☐ **NO**	*If yes, list body part &*		
date:					

Signature of Patient or Guardian Date

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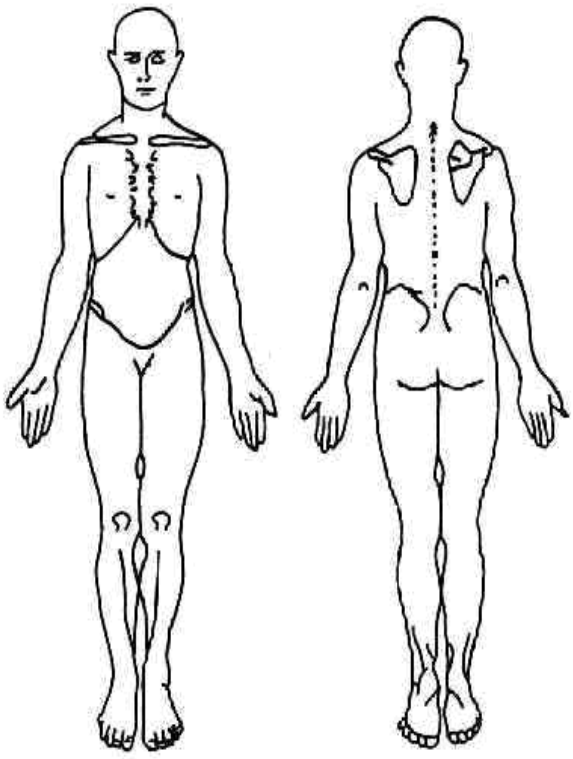
PAIN AND SYMPTOM STATUS REPORT

PATIENT NAME: **DATE:**

Describe how your injury occurred:

Date of Injury:

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



ACHE	BURNING	NUMBNESS
MMM	~~~	XXX
MM	~~	XX
PINS	**STABBING**	**OTHER**
□□□	///	000
□□	//	00

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