PATIENT INFORMATION

EMAIL ADDRESS:________________________

First Name:	Last Name:	Middle Initial:	Date:
Address:	City:	State:	Zip:
Birth date:	Age:	☐ Male ☐ Female	S.S. #:
Home Phone:	Alternative Phone (Cell, Pager):		Spouse:

Chose Clinic Because/ Referred to Clinic By ☐ Dr.: ☐ Insurance Plan ☐ Family ☐ Friend

☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other:

WORK INFORMATION

Employer:	Work Phone	Ext.
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ 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: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Name of Secondary Insurance:

Subscriber's Name:	Birth date :
ID. #:	Group/Policy #

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ 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 Med Center Therapy. I understand that I am financially responsible for any balance. I also authorize Med Center Therapy to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

PAST MEDICAL HISTORY FORM

Patient Name ____________________

BLOOD PRESSURE	YES	NO
Hypertension	☐	☐
Low Blood Pressure	☐	☐
Normal Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Myocardial Infarction	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
Do you have a pacemaker	☐	☐

MUSCLE CONDITION	YES	NO
Carpal Tunnel R/L	☐	☐
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐

OTHER CONDITIONS	YES	NO
Muscular Dystrophy	☐	☐
Rheumatoid Arthritis	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Polio	☐	☐

Other: ____________________

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day ____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week ____
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week ____
☐ 5+ x Week	☐ Heavy Labor			

What types of exercise do you perform? : ____________________

What things cause stress in your life? : ____________________

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?

☐ YES ☐ NO If yes list name: ____________________

List all medications you are currently taking: ____________________

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

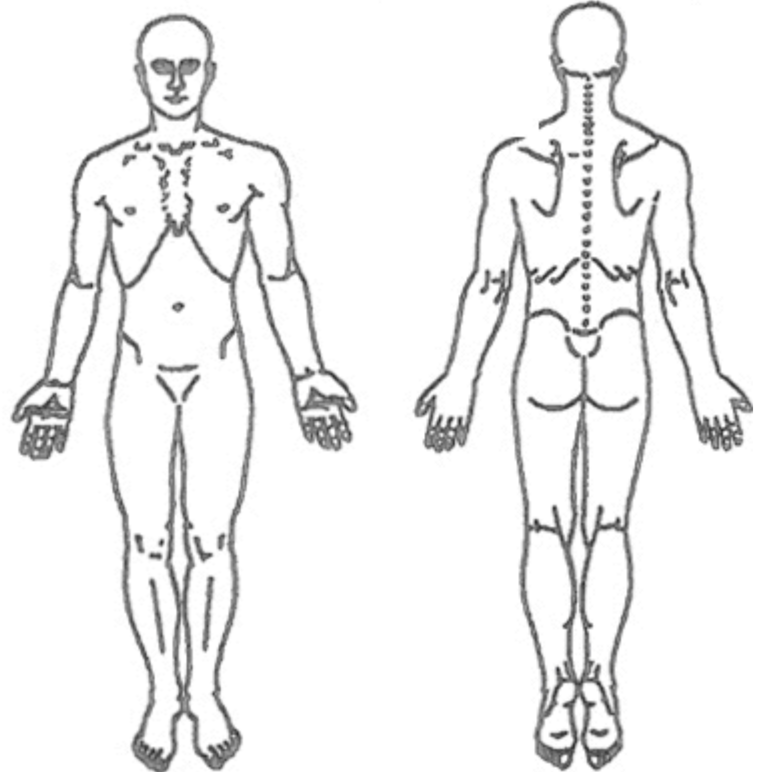
Pain and Symptom Status Report

Name: ______________________ **Date:** ______________

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

Ache	Burning	Numbness
MMM	— — —	O O O O
M	— —	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 ______________________