Welcome To

PERFORMANCE THERAPY

Please take a few moments to complete this form in its entirety. All information will be considered confidential and will be released only as allowed through HIPPAA regulations and as considered necessary for treatment, payment or other health care questions.

PATIENT INFORMATION

First Name	MI	Last Name	
Address			
City	State	Zip	
Home Phone	Cell Phone	Work Phone	
Date of Birth	Current Age	SSN	Sex
Marital Status (Circle One) Minor Single Married Divorced Widowed Separated			
Employer	Employer Address		
City	State	Zip Code	
Emergency Contact	Daytime Phone		
Primary Care Physician:			
Accident Related Yes No	Type: Auto Work Other	Date of Injury:	
How Did This Injury Occur?			
Doctor / Attorney:			
If Work Related: Case Worker's Name	Phone		
Who Can We Thank For Your Referral?			

RESPONSIBLE PARTY/ GUARANTOR INFORMATION

Name of person responsible for this account			
Relationship to patient	Daytime Phone	Home Phone	
Address	City	State	Zip
Employer		Employer Phone	

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Phone	Phone
Policy ID#	Policy ID#
Group#	Group#
Insured Name	Insured Name
Relationship to Patient	Relationship to Patient
Date of Birth	Date of Birth
SSN	SSN
Insured's Employer	Insured's Employer
Phone	Phone

PATIENT SIGNATURE_____ **DATE**_____

*A $50.00 charge will be given to cancellations when less than 24 hours notice is given.

Patient History

Name _____ **DOB**_____ **Age**___ **Date**_____

1. Describe the current problem that brought you here?_____

_____

2. When did your problem first begin?_____

3. Was your first episode of the problem related to a specific incident? Yes/No
Please describe and specify date _____

_____

4. Since that time is it: staying the _____ same _____ getting worse _____ getting better
Why or how?_____

5. If pain is present rate pain on a 0-10 scale 10 being the worst._____
6. Describe the nature of the pain (i.e. constant burning, intermittent ache)_____

_____

7. Describe previous treatment/exercises_____

_____

8. Activities/events that cause or aggravate your symptoms. Check/circle all that apply

__ Sitting greater than_____ minutes
__ Walking greater than _____minutes
__ Standing greater than _____ minutes
__ Changing positions (ie. - sit to stand)
__ Light activity (light housework)
__ Vigorous activity/exercise (run/weight lift/jump)
__ Sexual activity
__ Other, please list _____

__ With cough/sneeze/straining
__ With laughing/yelling
__ With lifting/bending
__ With cold weather
__ With triggers i.e. /key in door
__ With nervousness/anxiety
__ No activity affects the problem

9. What relieves your symptoms?_____

_____

10. How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (exclude physical activities), specify_____
Diet /Fluid intake, specify _____
Physical activity, specify _____
Work, specify _____
Other _____

11. Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst _____

12. What are your treatment goals/concerns?_____

_____

Since the onset of your current symptoms have you had:

Y/N	Fever/Chills	Y/N	Malaise (unexplained tirednes
Y/N	Unexplained weight change	Y/N	Unexplained muscle weakness
Y/N	Dizziness or fainting	Y/N	Night pain/sweats
Y/N	Change in bowel or bladder functions	Y/N	Numbness / Tingling

Y/N Other /describe_____
Date of Last Physical Exam _____ Tests performed_____

_____

Kathe Wallace
PHYSICAL THERAPY

Pg 2 History **Name** _____ **DOB ID#**_____ **Age**___

General Health: Excellent Good Average Fair Poor Occupation _____
Hours/week_____ On disability or leave?_____ Activity Restrictions? _____
Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week
Describe _____
Mental Health: Current level of stress High_ Med___ Low___ Current psych therapy? Y/N

Have you ever had any of the following conditions or diagnoses? Circle all that apply

Cancer	Stroke	Emphysema/chronic bronchitis
Heart problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple sclerosis	Allergies-list below
Ankle swelling	Head Injury	Latex sensitivity
Anemia	Osteoporosis	Hypothyroid/ Hyperthyroid
Low back pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/Tailbone pain	Fibromyalgia	Diabetes
Alcoholism/Drug problem	Arthritic conditions	Kidney disease
Childhood bladder problems	Stress fracture	Irritable Bowel Syndrome
Depression	Acid Reflux /Belching	Hepatitis
Anorexia/bulimia	Joint Replacement	Sexually transmitted disease
Smoking history	Bone Fracture	Physical or Sexual abuse
Vision/eye problems	Sports Injuries	Raynaud's (cold hands and feet)
Hearing loss/problems	TMJ/ neck pain	Pelvic pain

Other/Describe_____

Surgical /Procedure History

Y/N	Surgery for your back/spine	Y/N	Surgery for your bladder/prostate
Y/N	Surgery for your brain	Y/N	Surgery for your bones/joints
Y/N	Surgery for your female organs	Y/N	Surgery for your abdominal organs

Other/describe_____

Ob/Gyn History (females only)

Y/N	Childbirth vaginal deliveries #_	Y/N	Vaginal dryness
Y/N	Episiotomy #__	Y/N	Painful periods
Y/N	C-Section #____	Y/N	Menopause - when? __
Y/N	Difficult childbirth #__	Y/N	Painful vaginal penetration
Y/N	Prolapse or organ falling out	Y/N	Pelvic/genital pain_____
Y/N	Other /describe_____		

Males only

Y/N	Prostate disorders	Y/N	Erectile dysfunction
Y/N	Shy bladder	Y/N	Painful ejaculation
Y/N	Pelvic/genital pain location _____		
Y/N	Other /describe_____		

Medications - pills, injection, patch	Start date	Reason for taking

Over the counter -vitamins etc	Start date	Reason for taking