

Synergy Manual Physical Therapy

Patient Information

Date _____

Last name: _____ First name: _____

Address _____

City _____ State _____ Zip code _____

DOB: _____ Email _____ SSN _____ Male Female

Home phone: _____ Cell _____ Work _____

Marital Status: Single Married Partnered Divorced Widowed

Emergency Contact: _____ Phone: _____

Work Status: Full-Time Part-Time Not Employed Retired Medical Leave

Job Title: _____ Employer: _____

Duties: _____ Restrictions: _____

Referring Provider: _____ Primary Care Provider: _____

Was this a work injury? Yes No Date of injury: _____ Claim # _____

Was this an auto injury? Yes No Date of accident: _____ Claim # _____

If yes, is someone else responsible for payment? Yes No

Is an attorney involved in your case? Yes No Name: _____

Primary Insurance: _____ Policy ID# _____

Insurance Phone Number: _____

Policy Holder _____ Holder's DOB _____

Secondary Insurance: _____ Policy ID# _____

Policy Holder _____ Holder's DOB _____

Insurance Phone Number: _____

Have you had previous physical therapy treatment? Yes No Dates _____

Area(s) treated? _____

Authorization to Treat and to Release Medical Information:

- ~ I consent to treatment by Synergy Manual Physical Therapy, PC.
- ~ I hereby authorize the release of pertinent medical information to my insurance agency for the maintenance of my health, or the processing of any insurance claim.
- ~ A copy of this facility's "Statement of Privacy Notice" has been provided to me.

Signature of Patient or Guardian

Date

Synergy Manual Physical Therapy

Pain Questionnaire

Name _____ Date _____

Current complaint: _____

Date of onset: _____ Symptoms have: improved worsened not changed

Describe onset: _____

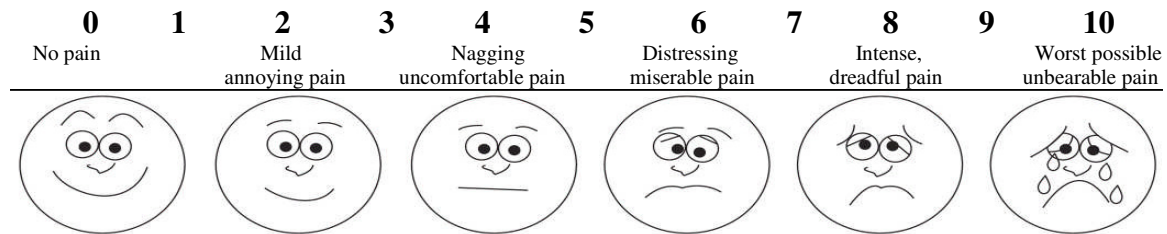
Describe pain: _____

What increases the pain? _____

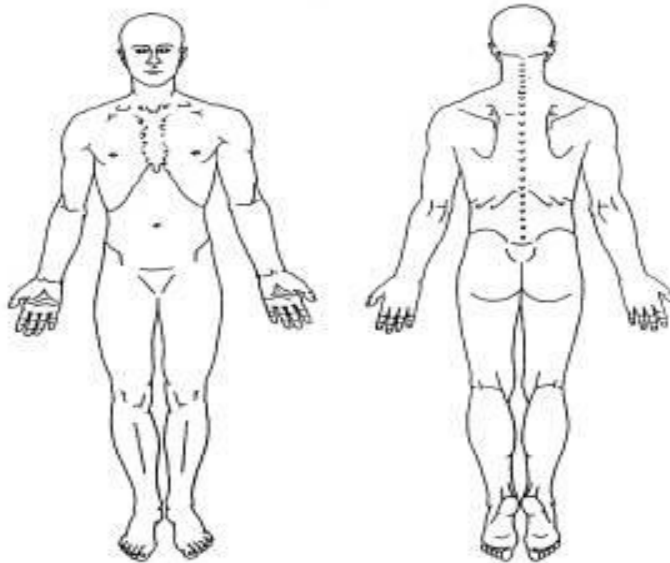
What decreases the pain? _____

Rate your pain from 0 to 10 using the following scale:

Currently: _____ At rest: _____ At best: _____ At worst: _____



Below mark with an "X" to designate your current area of pain



Have you had any of the following for your current condition?

- | | | | |
|----------------------------------|------------|--------------------------------------|------------|
| <input type="checkbox"/> MRI | date _____ | <input type="checkbox"/> Bone Scan | date _____ |
| <input type="checkbox"/> CT Scan | date _____ | <input type="checkbox"/> Nerve Study | date _____ |
| <input type="checkbox"/> X-rays | date _____ | <input type="checkbox"/> Other | _____ |

Synergy Manual Physical Therapy

Name _____ Date _____

List any surgeries as it relates to your current condition:

Circle any condition you have ever had:

Cancer	High Blood Pressure	Bowel/Bladder Changes	HIV/AIDS
Diabetes	High Cholesterol	Vascular Disease	Depression
Dizziness	Heart Disease	Head Injury	Anxiety
Osteoporosis	Pacemaker	Multiple Sclerosis	Asthma
Osteo-arthritis	Stroke	COPD	Hepatitis
Rheumatoid Arthritis			

List any pertinent family history:

List your current medications:

List your allergies (drugs, latex, adhesives, chemicals, etc.):

Please note any additional information that would assist us in your care (e.g., apprehensions, special needs and/or religious or cultural considerations).

What is your goal for physical therapy?

By signing below, I commit to my physical therapy program. This includes attending scheduled appointments and being compliant with my home exercise program. I will inform my therapist should my condition change.

Signature of Patient: _____ Date: _____