Synergy Manual Physical Therapy

Demographics

Date_____

Name: Last: _____First:_____

Address: _____

City: _____ State: ____ Zip Code: _____ DOB: _____

Email: _____ SSN: _____

Phone: Home_____ Cell_____ Work_____

Marital Status: □ Single □ Married □ Partnered Sex: □ Male □ Female

Emergency Contact: _____ Phone: _____

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

Job Title: _____ Employer: _____

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 #: _____

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

Primary Insurance: _____Phone Number: _____

Policy ID#:_____Policy Holder: _____Holder's DOB: _____

Secondary Insurance: _____ Phone Number: _____

Policy ID#:_____Policy Holder: _____Holder's DOB: _____

Previous Physical Therapy Treatment? □ Yes □ No Dates_____

What area was treated? _____

How did you hear about us? □ Family/friend □ Advertisement □ Booth □ Doctor □ Other_____

Do we have permission to leave message on your voicemail regarding your appointments? □ Yes □ No

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

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Pain Questionnaire

Name_____ Date _____

Current Complaint:_____

Date of Onset: _____ Restrictions: _____

History of Present Condition:_____

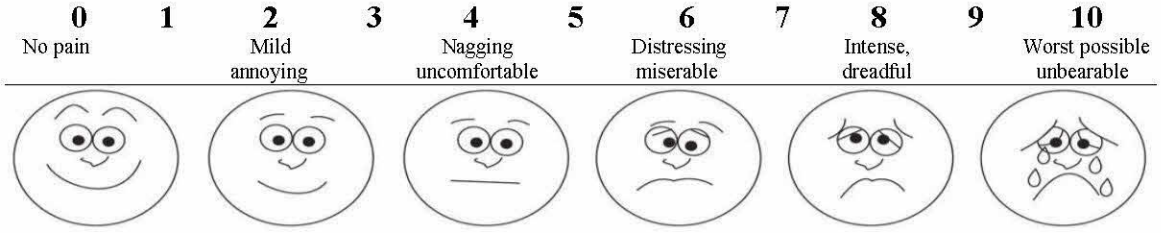
Describe symptoms: _____

What increases the symptoms? _____

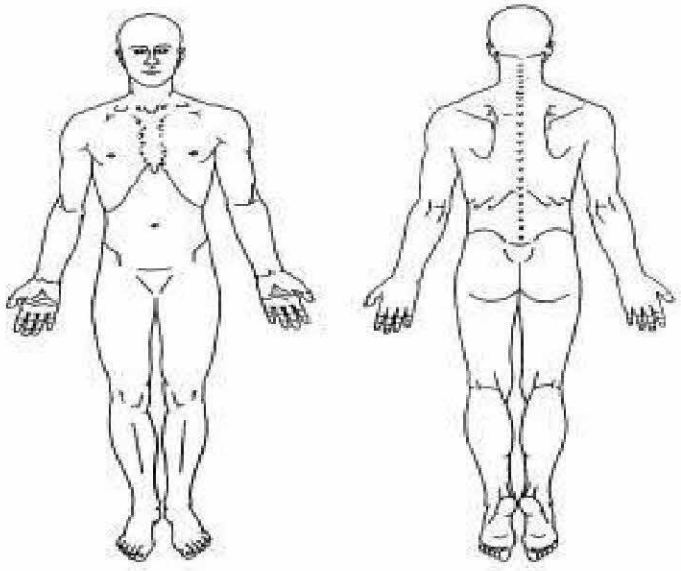
What decreases the symptoms? _____

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

At Worst: _____Currently: _____ At Best: _____



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



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

☐ MRI date _____ ☐ Bone Scan date _____

☐ CT Scan date _____ ☐ Nerve Study date _____

☐ X-rays date _____ ☐ Other _____

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Medical History

Name _____ **Date:** _____

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
RA			

List any surgeries as it relates to your current condition:

_____

_____

List current medications:

_____

_____

_____

Medical Allergies (drugs, latex, adhesives, chemicals):

_____

_____

Please note any additional information that would assist us in your care. (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: _____