ARCH

PHYSICAL THERAPY AND PILATES CENTER

First Name _____ Last Name _____ Date of Birth _____ □ Male □ Female

Home Street Address _____ City _____ State _____ Zip _____

Cell Phone # _____ Home Phone # _____ E-Mail Address _____

Emergency Contact _____ Relationship _____ Contact Phone # _____

Referring Physician/Direct Access _____ Primary Care Physician (if different than referral) _____

How did you hear about us? □ Physician □ Family/Friend □Internet □ other

Primary Insurance _____ Member ID # _____ Provider Phone # _____

Secondary Insurance _____ Member ID# _____ Provider Phone # _____

If a family member is the Primary Insurance holder, please list their name and date of birth:

Payment Options

□ I have insurance (please complete Assignment of Benefits Form authorizing us to deal with them for you)

□ This is a work or auto accident

□ I will be "self-pay"

Patient Signature _____ Date _____

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PRE-EXAMINATION QUESTIONNAIRE

Have you had physical therapy before? □ Yes □ No If Yes, Why? _____

_____

Please describe your problem: _____

_____

_____

What caused your pain/problem? _____

_____

Approximately when did it begin?_____/_____/____

Is the pain/problem getting worse, better or staying the same? _____

What makes the problem better?_____

What makes the problem worse? _____

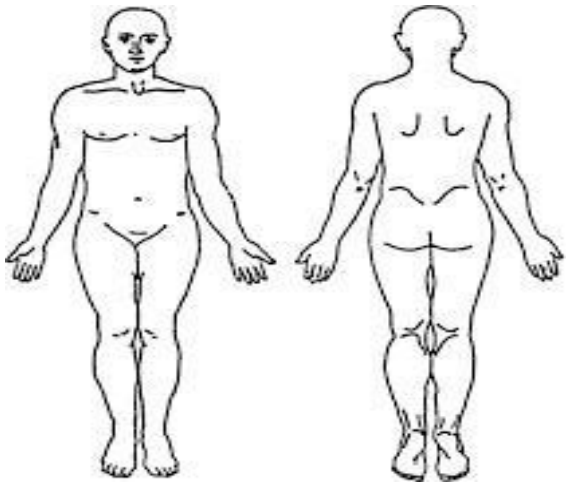
What activities are you unable to do now secondary to pain/problem?

_____

What are your goals in physical therapy or your recovery?

_____

Using diagram please mark your painful areas:



Score your pain level on your pain:

0 = no pain 5= pain limits you 10= ER admit

At best: 0 1 2 3 4 5 6 7 8 9 10

At worst: 0 1 2 3 4 5 6 7 8 9 10

Current: 0 1 2 3 4 5 6 7 8 9 10

Circle words that describe your pain:

Aching Burning Cramping Dull Numbness

Radiating Sharp Sore Stiff Tight Tingling

How frequently do you feel your pain?

_____Intermittently < 25%

_____Occasionally < 25-50%

_____ Frequently < 51-75%

_____ Constantly > 75%

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For this problem, have you had any of the following: □Xray □MRI □CT Scan □EMG □Injection
Have you ever been diagnosed as having any of the following conditions?

Cancer □Yes □No
Type:_____
Vascular issues □Yes □No
Heart Attack □Yes □No
High Blood Pressure □Yes □No
Stroke □Yes □No
Deep Vein Thrombosis/DVT □Yes □No
Anemia/low blood levels □Yes □No
Pacemaker/Defibrillator □Yes □No
Lung Problems □Yes □No
Asthma □Yes □No

Broken bone/Fracture: □Yes □No
Type:_____
Osteoporosis □Yes □No
Osteopenia □Yes □No
Diabetes □Yes □No
Depression □Yes □No
Headache □Yes □No
Memory Problems □Yes □No
Hearing Problems □Yes □No
Vision Problems □Yes □No
Dizziness/Vertigo □Yes □No

Other Conditions: _____

Surgeries:

Type:_____ Date: _____
Type:_____ Date: _____
Type: _____ Date: _____

Current Medication:

_____
_____
_____

Do you have a latex allergy? □Yes □No Other allergies: _____

Do you exercise regularly? □Yes □No What type and how often? _____

_____

Have you fallen in the past year? □Yes □No When? _____
Check if you use: □ Cane □Walker □Crutches □Forearm Crutches □Manual w/c □Power w/c

_____ _____
Patient Signature Date