



PATIENT INFORMATION		EMAIL ADDRESS:	
First Name:	Last Name:	Middle Initial:	Date: / /
Address:		City:	State: Zip:
Birth date: / /	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -		Spouse:
Chose Clinic Because/ Referred to Clinic By <input type="checkbox"/> Dr.: <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Family <input type="checkbox"/> Friend			
<input type="checkbox"/> Former Patient <input type="checkbox"/> Close to Work/Home <input type="checkbox"/> Website <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Street Sign <input type="checkbox"/> Other:			
WORK INFORMATION			
Employer:		Work Phone ( ) -	Ext.
Occupation:	Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:			
Name of Secondary Insurance:			
Subscriber's Name:			Birth date : / /
ID. #:	Group/Policy #		
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:			
AUTO OR WORK INJURY CLAIM		( PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP )	
Insurance Name: <input type="checkbox"/> Auto : <input type="checkbox"/> 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 Campbell Physical Therapy & SportsCare. I understand that I am financially responsible for any balance. I also authorize Campbell Physical Therapy & SportsCare to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE

DATE



**PAST MEDICAL HISTORY FORM**

**Patient Name** \_\_\_\_\_

BLOOD PRESSURE			JOINT CONDITIONS		
	YES	NO		YES	NO
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
Normal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremity Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE			OTHER CONDITIONS		
	YES	NO		YES	NO
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerotic Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
MUSCLE CONDITION			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
	YES	NO	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Carpal Tunnel R/L	<input type="checkbox"/>	<input type="checkbox"/>	Poor Eyesight	<input type="checkbox"/>	<input type="checkbox"/>
Tennis Elbow R/L	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Back/Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
Limited Limb Movement	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
			_____		
			_____		
LUNGS					
	YES	NO			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>			
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>			
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>			

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Low	<input type="checkbox"/> Smoking	Packs a Day _____
<input type="checkbox"/> 1-2 x Week	<input type="checkbox"/> Standing	<input type="checkbox"/> Medium	<input type="checkbox"/> Alcohol	Drinks a Week _____
<input type="checkbox"/> 3-4 x Week	<input type="checkbox"/> Light Labor	<input type="checkbox"/> High	<input type="checkbox"/> Coffee/Soda	Cups a Week _____
<input type="checkbox"/> 5+ x Week	<input type="checkbox"/> 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

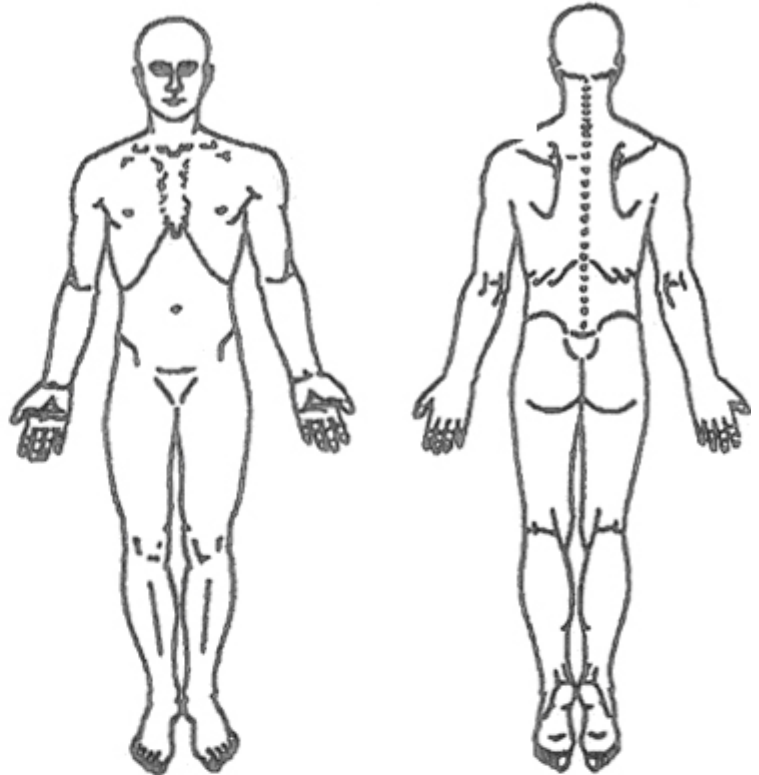
Date

# 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**  
MMM  
M

**Burning**  
---  
---

**Numbness**  
OOOO  
OOO

**Pins and Needles**  
□□□□□□□□  
□□□□□□□□

**Stabbing**  
/////

**Other**  
xxxx  
xxx

## 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 CURRENT 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 AVERAGE 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 WORST level of pain:**

**No Pain**    0    1    2    3    4    5    6    7    8    9    10    **Pain as bad as it gets.**

Additional Comments: \_\_\_\_\_



### AGREEMENT TO PAY

I understand and agree that I am responsible and liable for payment of all charges assessed for professional services rendered. I understand insurance claims forms will be submitted to my insurance company as a matter of convenience to me and I am primarily responsible for all charges regardless of my existing medical coverage. In the event my insurance company forwards payment directly to me, I will deliver such payment to Campbell Physical Therapy.

I authorize payment of medical benefits to Campbell physical therapy for services rendered. (A copy of this authorization can be considered as an original for insurance purposes. I also give consent to receive physical therapy treatments).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If you would like us to , we can automatically apply your portion of the bill to your Visa or Mastercard.

I here by authorize: Campbell Physical Therapy  
163 E. Hamilton Ave.  
Campbell, CA 95008

To apply my balance ot my charge card account

Visa                       Mastercard                       Other

Expires on: \_\_\_\_\_