



| 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 DS Physical Therapy & SportsCare. I understand that I am financially responsible for any balance. I also authorize DS Physical Therapy & SportsCare to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE

DATE



PAST MEDICAL HISTORY FORM

We are interested in how you feel about how well you are able to do your usual activities. This information will help us take better care of you. Please answer the questions based on the problem for which you are receiving treatment. If you do not do or have not done this activity, please make your best guess as to which response is most accurate.

| Today, does or would your health problem limit: | Yes, limited a lot | Yes, limited a little | No, not limited at all | |
|--|---|---|--|--|
| 1. Participating in rigorous contact sports | | | | |
| 2. Lifting 50lbs or more | | | | |
| 3. Vigorous activities like running, lifting heavy objects, sports, running more than 5 miles? | | | | |
| 4. Participating in recreation? | | | | |
| 5. Moderate activities, such as moving a table or pushing a vacuum cleaner? | | | | |
| 6. Climbing several flights of stairs? | | | | |
| 7. Climbing one flight of stairs? | | | | |
| 8. Walking more than a mile? | | | | |
| 9. Walking several blocks? | | | | |
| 10. Walking one block? | | | | |
| 11. Going on vacation? | | | | |
| 12. Attending social events? | | | | |
| 13. Lifting or carrying items like groceries? | | | | |
| 14. Lifting overhead to a cabinet? | | | | |
| 15. Gripping or opening a can? | | | | |
| 16. Handling of small items such as a pen or coins? | | | | |
| 17. Feeding yourself? | | | | |
| 18. Getting in and out of bed? | | | | |
| 19. Bathing or dressing? | | | | |
| 20. Bending to the floor? | | | | |
| 21. Kneeling to the floor? | | | | |
| 22. Control of your bladder? | | | | |
| 23. Completing your toileting? | | | | |
| 24. Do you limit the kind of work or other daily activities as a result of your physical health? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| 25. Do you reduce the amount of time you spend on work or other regular daily activities as a result of your physical health? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| 26. How much does pain interfere with your normal work (including work outside the home, work around the yard, and housework)? | <input type="checkbox"/> Extremely | <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Moderately | <input type="checkbox"/> Not at all |
| 27. How much pain have you had in the past 24 hours? | <input type="checkbox"/> Severe | <input type="checkbox"/> Moderate | <input type="checkbox"/> Mild | <input type="checkbox"/> None |

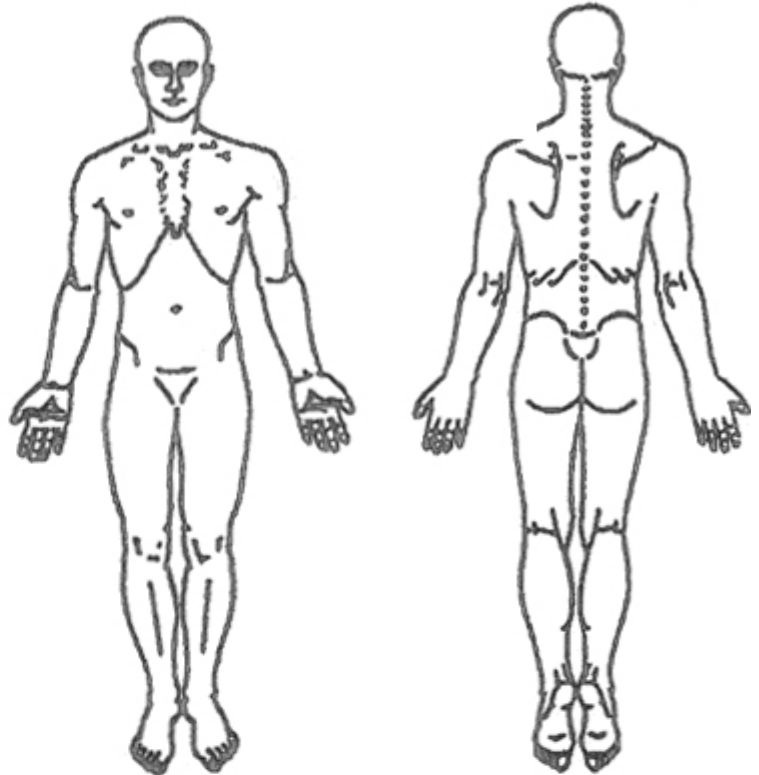
| | | | | | | | |
|---|-------------------------------|----------------------------|---|-----------------------------------|--|------------|-----------|
| 28. Please indicate the number of surgeries | <input type="checkbox"/> None | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 <input type="checkbox"/> 3 | <input type="checkbox"/> 4+ | | | |
| 29. Do you limit the kind of work or other daily activities as a result of your physical health? _____ Yes _____ No | | | | | | | |
| 30. Do you reduce the amount of time you spend on work or other regular daily activities as a result of your physical health? _____ Yes _____ No | | | | | | | |
| 31. How much does pain interfere with your normal work (including work outside the home, work around the yard and housework?) _____ Extremely _____ Quite a bit _____ Moderately _____ Not at all | | | | | | | |
| 32. How much pain have you had during the past 24 hours? _____ Severe _____ Moderate _____ Mild _____ None | | | | | | | |
| 33. Are you taking prescription medication for this condition? _____ Yes _____ No | | | | | | | |
| 34. How often have you completed at least 20 minutes of exercise such as jogging, cycling, or brisk walking, prior to the onset of your condition? _____ At least 3x a week _____ Once or twice a week _____ Seldom or never | | | | | | | |
| 35. Indicate the number of surgeries for your primary condition: _____ None _____ 1 _____ 2 _____ 3 _____ 4 or more | | | | | | | |
| 36. How many days ago did this condition begin? _____ 0-7 _____ 8-14 _____ 15-21 _____ 22-90 _____ 91-6 months _____ More than 6 months | | | | | | | |
| 37. I should not do physical activities which (might) make my pain worse: _____ 0-Completely disagree _____ 1 _____ 2 _____ 3 Unsure _____ 4 _____ 5 _____ 6-Completely Agree | | | | | | | |
| Blood Pressure | | YES | NO | Lungs | | Yes | No |
| Hypertension | | _____ | _____ | Asthma | | _____ | _____ |
| Low Blood Pressure | | _____ | _____ | Emphysema | | _____ | _____ |
| Normal Blood Pressure | | _____ | _____ | Shortness of Breath | | _____ | _____ |
| Heart Disease | | | | Joint Conditions | | | |
| Heart Attack | | _____ | _____ | Upper Extremity | | _____ | _____ |
| Myocardial Infarction | | _____ | _____ | Dislocation | | _____ | _____ |
| Rheumatic Heart Disease | | _____ | _____ | Lower Extremity Dislocation | | _____ | _____ |
| Heart Murmur | | _____ | _____ | | | | |
| Pacemaker | | _____ | _____ | | | | |
| Muscle Condition | | | | Other Conditions | | | |
| Carpal Tunnel | | _____ | _____ | Muscular Dystrophy | | _____ | _____ |
| Tennis Elbow | | _____ | _____ | Rheumatoid Arthritis | | _____ | _____ |
| Back/Neck Problems | | _____ | _____ | Multiple Sclerosis | | _____ | _____ |
| Limited Limb Movement | | _____ | _____ | Epilepsy | | _____ | _____ |
| | | | | Gout | | _____ | _____ |
| 38. Are you pregnant? _____ Yes _____ No | | | | 39. What things cause you stress: | | | |
| 40. Height: _____ ft _____ in | | | | 41. Weight: _____ | | | |

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: _____