

**PATIENT DEMOGRAPHICS**

Name:\* \_\_\_\_\_  
Parents or Guardian(if minor): \_\_\_\_\_  
Address:\* \_\_\_\_\_  
City:\* \_\_\_\_\_ State:\* \_\_\_\_\_  
Zip:\* \_\_\_\_\_  
Email:\* \_\_\_\_\_  
Phone Number:\* \_\_\_\_\_

Date of Birth:\* \_\_\_\_\_ Age \_\_\_\_\_  
Gender:\*  Male  Female  
Marital Status:  Single  Married

**EMERGENCY CONTACT**

Name:\* \_\_\_\_\_  
Relationship:\* \_\_\_\_\_  
Phone Number:\* \_\_\_\_\_

How did you hear about us? \_\_\_\_\_  
Do you have a provider prescription?  Yes  No  
Next provider visit: \_\_\_\_\_

Referring provider: \_\_\_\_\_  
Do you authorize Function P.T. to discuss your treatment with your referring provider?  Yes  No

**OCCUPATIONAL INFORMATION**

Employer Name: \_\_\_\_\_  
Occupation: \_\_\_\_\_

Currently Working:  Yes  No

**INSURANCE INFORMATION**

Primary Insurance Carrier:\* \_\_\_\_\_

Member ID#: \_\_\_\_\_

Group #: \_\_\_\_\_

Primary Subscriber Name: \_\_\_\_\_

Date of Birth:\* \_\_\_\_\_ Age \_\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_

Member ID#: \_\_\_\_\_

Group #: \_\_\_\_\_

Secondary Subscriber Name: \_\_\_\_\_

Date of Birth:\* \_\_\_\_\_ Age \_\_\_\_\_

**HISTORY OF PRESENT CONDITIONS**

 Body Part/Region: \_\_\_\_\_ Side (if applicable):  Right  Left  Both

When did your symptoms begin? \_\_\_\_\_

 Are your symptoms:  Constant  Intermittent  Improving  Worsening  Unchanging  Activity Dependent

 Did you have surgery?  Yes  No If Yes, Date: \_\_\_\_\_ Type of Surgery: \_\_\_\_\_

How did you hurt yourself? \_\_\_\_\_

What is your primary concern / chief complaints? \_\_\_\_\_

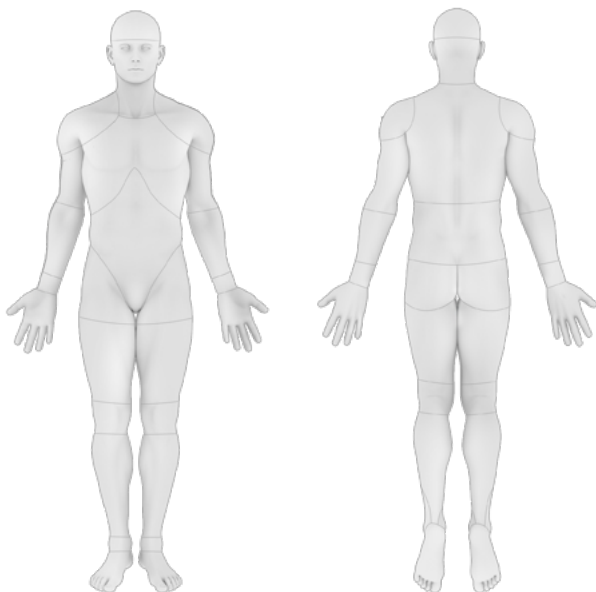
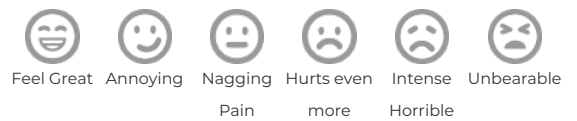
 Have you received treatment for this before?  Yes  No Did it get better?  Yes  No

Where? \_\_\_\_\_ When? \_\_\_\_\_

 Do your symptoms interrupt your sleep?  Yes  No

 Does coughing, sneezing or taking a deep breath change your symptoms?  Yes  No

 When is your pain the worst?  Morning  Night  At Rest  During Activity  After Activity

**PAIN DRAWING**

**PAIN RATING** (Please rate your pain in the scale below, circle the number that best represents your pain)

 Worst pain in the past 48 hours:  0  1  2  3  4  5  6  7  8  9  10

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

 Best pain in the past 48 hours:  0  1  2  3  4  5  6  7  8  9  10

 What makes your pain worse? 

 What makes your pain better? 
**PATIENT MEDICAL SCREENING QUESTIONNAIRE**

 Do you smoke?  Yes  No Do you have a pacemaker?  Yes  No

 Do you use a:  Cane  Walker  Wheelchair  Other \_\_\_\_\_

 Women only: Are you currently pregnant or think you may be pregnant?  Yes  No

**Past Medical History:** (Please check all that apply.)

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Alzheimer's                | <input type="checkbox"/> Diabetes Type 2                | <input type="checkbox"/> Immunosuppression  | <input type="checkbox"/> Rheumatoid Arthritis   |
| <input type="checkbox"/> Cardiovascular Disease     | <input type="checkbox"/> Fibromyalgia                   | <input type="checkbox"/> Lupus              | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Cauda Equina Syndrome      | <input type="checkbox"/> Fracture or Suspected Fracture | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Asthma                 |
| <input type="checkbox"/> Cerebral Vascular Accident | <input type="checkbox"/> High Blood Pressure            | <input type="checkbox"/> Obesity            |   |
| <input type="checkbox"/> Current Infection          | <input type="checkbox"/> History of Cancer              | <input type="checkbox"/> Osteoarthritis     |   |
| <input type="checkbox"/> Diabetes Type I            | <input type="checkbox"/> Huntington's                   | <input type="checkbox"/> Parkinson's        |   |
| <input type="checkbox"/> Other _____                |   |   |   |
| <input type="checkbox"/> If none apply check here   |   |   |   |

Please list any surgeries or other conditions, with dates, for which you have been hospitalized:

Please list any previous significant injuries and date:

Please list any diagnostic tests (x-rays, MRI, EMG, CT etc.) relevant to your current chief complaint and dates performed:

**Have you RECENTLY noted any of the following:** (Please check all that apply.)

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Fatigue                           | <input type="checkbox"/> Sudden Weight Loss/Gain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fever/Chills          |
| <input type="checkbox"/> Headaches                         | <input type="checkbox"/> Difficulty Walking      | <input type="checkbox"/> Loss of Balance     | <input type="checkbox"/> Nausea/Vomiting       |
| <input type="checkbox"/> Falls                             | <input type="checkbox"/> Difficulty Swallowing   | <input type="checkbox"/> Numbness/Tingling   | <input type="checkbox"/> Constipation/Diarrhea |
| <input type="checkbox"/> Dizziness                         | <input type="checkbox"/> Lightheadedness         | <input type="checkbox"/> Muscle Weakness     | <input type="checkbox"/> Heartburn/Indigestion |
| <input type="checkbox"/> Changes in Bladder/Bowel Function |  | <input type="checkbox"/> Depression          |  |
| <input type="checkbox"/> If none apply check here:         |  |  |  |

Please list current medications, over the counter medication, vitamins, and supplements (include dosage and purpose):

If you are currently not taking any medications please check here: 

What are your goals or things you want to get back to doing?

**CONSENT TO EVALUATE AND TREAT**

I hereby request and consent to the performance of various modes of physical therapy on me (or the patient named below, for whom I am legally responsible) by a licensed physical therapist employed by Function Physical Therapy, LLC. I understand as a patient, that Function Physical Therapy, LLC is not liable for any act when providing treatment in accordance of my physical condition. I acknowledge that no guarantee or assurance has been, nor can be, made by Function Physical Therapy, LLC as to the result of the prescribed treatment. By signing this agreement, I confirm that I have read and fully understand this consent form and I understand this consent may be revoked by me at any time

**OUR PRIVACY POLICY**

Function Physical Therapy is committed to upholding the security and confidentiality of personal information that you provide to us. We do not share or sell patient information with anyone outside of our office without your written consent. This covers information including personal, financial or health information.

I understand that under the Health Insurance Portability and Accountability Act (HIPPA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment directly and indirectly, obtain payment from third party payers and conduct normal healthcare operations such as quality assessments and physicians' certification. I acknowledge that the notice of privacy policies was provided to me to be read and give authorization to Function Physical Therapy, LLC to use and disclose my protected health information for the uses listed to me.

*By agreeing below, I have read, or have had read to me, the above consent to evaluation and treatment statement, that I am aware of the privacy policy, and that I certify that the medical information above is correct to the best of my knowledge.*

Patient's Initials:\* \_\_\_\_\_  
(parent/guardian if  
minor)

Guardian  
Relationship: \_\_\_\_\_

Full Name:\* \_\_\_\_\_

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