PHASE 1 PHYSICAL THERAPY, PS
Your First Phase Towards Injury Prevention and Recovery
6066 Highway 291 Nine Mile Falls, WA 99026
(W) 509.465.5663 (F) 509.467.8663

Patient Demographics

Date:_____

_____ ____/_____/_____
Full Legal Name: First Middle Last Date of Birth

_____ Male/Female
If Minor (under 18) Parent/Guardian name (Circle One)

_____ _____ _____ _____
Address: Street City State Zip Code

Home Phone(_____)_____ Cell Phone(_____)_____Work Phone(____)_____

Appointment Reminders: Text or Voice (circle one)

_____ _____ _____
Emergency Contact Name Relationship Phone#

_____ _____
Patient's Employer Phone #

---------- _____
Name of Referring Physician Phone #

_____ _____
Name of Primary Physician (if different than Referring Doctor) Phone #

Are you a previous patient? Yes or No - If no , how did you hear about us?
Physician_____ Online_____Family/Friend_____Other_____

Have you had any previous physical therapy this year? Yes/No Where_____

Insurance Information

_____ _____ _____
Primary Insurance Company Policy ID # Group #

_____ ___/____/_____ _____
Policy Holder's Name Date of Birth Relationship to Patient

_____ _____ _____
Secondary Insurance Company Policy ID # Group #

_____ ___/____/_____ _____
Policy Holder's Name Date of Birth Relationship to Patient

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Worker's Compensation or Motor Vehicle Accident Information

_____ ____/____/_____ _____
Company Name Date of Injury Claim #

_____ _____
Claims Manager Name Claims Manager Phone number

_____ _____
Address City/State/Zip

_____ _____
Employer (if Workman's Comp) Phone Number

I hereby consent to treatment by Phase 1 Physical Therapy, PS and authorize the release of any and all information acquired in the course of my treatment or dealing in any manner with my treatment, including, but not limited to my insurance company, employer, PCP, or referring physician, or other third party payer. I agree to hold Phase 1 Physical Therapy, PS harmless from the release of any of this information. I realize that I have the right to refuse any procedure after having the risks and benefits explained to me. I authorize payment to be made directly to Phase 1 PT for all services rendered. It is understood that I am ultimately responsible for the fees. I also authorize Phase 1 Physical Therapy, PS access to any and all information acquired in the course of my treatment to use in health care operations including quality assessment activities, professional comp review, audit and compliance activities and record review for coverage and utilization review. I understand that any quote of benefits from the insurance company is not a guarantee of payment and I am responsible for any balance not covered by Insurance.

I acknowledge that I have received a copy of the Patient Rights and Responsibilities brochure.

I understand that receiving physical therapy care does involve treatment in an open area, there by not providing full privacy at all times. If you feel uncomfortable with discussing your medical history, current problem, or plan of care in an open area, please notify your therapist before the assessment begins and accommodations will be made.

_____ _____
Signature of Patient or Guardian if Minor Date

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History of Present Conditions

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:** _____

Have you experienced these same or similar symptoms prior to this episode? ○ Yes ○ No **When?** _____

How did your injury/issue start?

What is your primary concern?

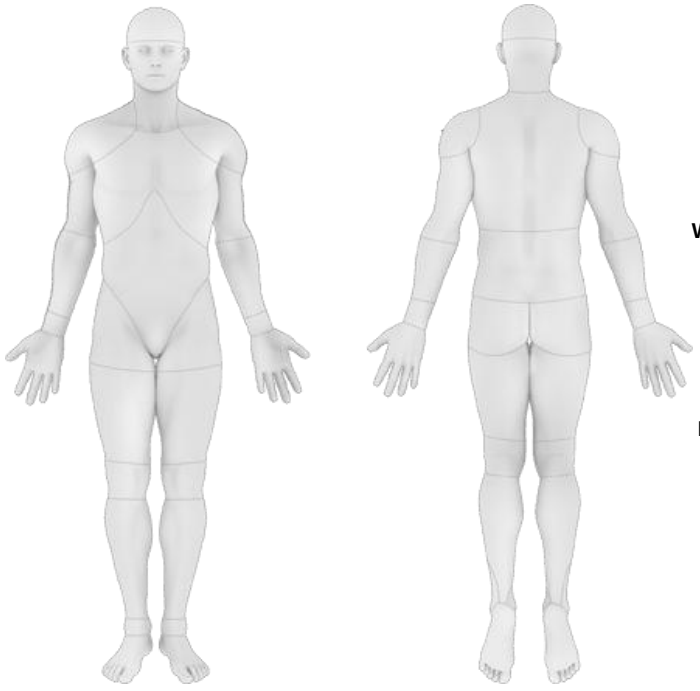
Have your received treatment for this before? ○ Yes ○ No **Did it get better?** ○ Yes ○ No

What treatment did you receive? _____ **When did you receive treatment?** _____

Do your symptoms interrupt your sleep? ○ Yes ○ No

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

Pain Drawing



Mark your current pain location on the picture above

Pain Rating - please rate your pain using the scale below, circle the number that best represents your pain:

Feel Great — Annoying — Nagging Pain — Hurts Even Worse — Intense Horrible — Unbearable

	0	1	2	3	4	5	6	7	8	9	10
Worst pain in the past week:	○	○	○	○	○	○	○	○	○	○	○
Current pain intensity:	○	○	○	○	○	○	○	○	○	○	○
Least pain the past week:	○	○	○	○	○	○	○	○	○	○	○

What makes your pain worse?

What makes your pain better?

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Patient Medical Screening Questionnaire

Do you smoke/use tobacco? ○ Yes ○ No **Do you have a pacemaker?** ○ Yes ○ No

Do you use assistive devices: ○ 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, if none apply check here:** ☐

☐ Alzheimer's	☐ Diabetes	☐ Lupus	☐ Asthma
☐ Cardiovascular Disease	☐ Fibromyalgia	☐ Osteoarthritis	☐ Dizziness/Fainting
☐ Cerebral Vascular Accident	☐ Fracture or Suspected Fracture	☐ Parkinson s	☐ Bowel/Bladder Abnormality
☐ Current Infection	☐ High Blood Pressure	☐ Headaches	
☐ Osteoporosis	☐ History of Cancer	☐ Rheumatoid Arthritis	
☐ Urine Leakage	☐ Immunosuppression	☐ Traumatic Brain Injury	

☐ Other: _____

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

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