One to One Physical Therapy

2312 N 30th St., Suite 101, Tacoma, WA Ph. (253) 396-9001 Fax (253) 396-1231 Website: www.121pt.com

PATIENT INFORMATION

Today's Date _____

Name: (Last) _____ (First) _____ (M.I.) _____

Home Address _____ Birth Date _____

City _____ State _____ Zip _____ SSN _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ ☐ Full Time ☐ Part Time ☐ Not Currently Working ☐ Retired

Occupation _____ How did you hear about us? _____

Emergency Contact Person _____ Emg. Contact Ph. # _____

INJURY INFORMATION

Injury Type ☐ Work ☐ Auto ☐ Home ☐ Other _____ Date of Injury _____

Area's Being Treated _____ ☐ L ☐ R

Referring MD _____ ☐ MD ☐ Chiro ☐ PA ☐ ARNP Primary MD _____

Are you, or have you had Speech, Occupational, Massage, or Physical Therapy during the past year? ☐ Yes ☐ N0

If yes to above, please explain. _____

INSURANCE INFORMATION

Primary Insurance _____ Insurance I.D. # _____

Insurance Co. Phone #. _____ Note, please bring you insurance card to your first appointment.

Subscriber Name _____ Birth Date _____ SSN _____

Primary Subscriber ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Rep or Claim Manager (if applicable) _____

Secondary Insurance _____ Insurance I.D. # _____

Subscriber Name _____ Birth Date _____ SSN _____

Primary Subscriber ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

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Medical History

Today's Date _____

Name _____ Referring MD _____ Last seen _____

Birth Date _____ Age _____ Family MD _____ Last seen _____

Describe your pain/problem. ☐ Right ☐ Left _____

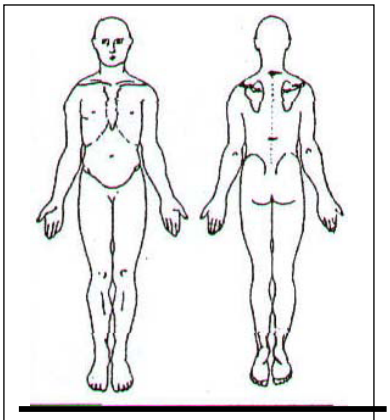
_____

What Makes it worse ? _____

_____

What Makes it better? _____

_____



After printing, please number on the drawing the areas where you feel pain.
1.Sharp, **2.** Achy, **3**.Stiff, **4.** Stabbing

This problem is due to . ☐ Fall/Injury Date _____

☐ Motor vehicle accident Date _____

☐ Surgery Date _____ Other _____

☐ Long standing problem Approximate duration _____

Have you had this problem before? ☐ Yes ☐ No

How did this injury happen? _____

Check the number that best describes your average daily pain, 0 (no pain) to 10 (unbearabe pain).

☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10**

What number best describes your very worst pain complaint since it stated? _____

Other important details. _____

_____

Have you had Physical Therapy before? ☐ Yes ☐ No If yes, was it in the current calendar year? ☐ Yes ☐ No

Are you now under the care of another Physical/Occupational/or Speech Therapist at home or elsewhere?. ☐ Yes ☐ No

What medications are you currently taking? _____

_____

WOMEN -- I am or may be pregnant. ☐ Yes ☐ No Surgery history. _____

Special tests related to this problem. Check all that apply. ☐ MRI ☐ CT Scan ☐ Bone scan ☐ X-rays

Other test? _____ When? _____ Results _____

Medical History: Please check any that apply to you.

- ☐ Cancer/tumors
- ☐ Epilepsy/seizures
- ☐ Frequent falls
- ☐ Headaches
- ☐ Osteoporosis
- ☐ Blackouts
- ☐ Arthritis
- ☐ Ear ringing
- ☐ Poor Circulation
- ☐ Shortness of breath
- ☐ Night pain
- ☐ Asthma
- ☐ Dizziness
- ☐ Blurred vision
- ☐ Heart problems/angina
- ☐ Pacemaker/nitro patch
- ☐ Thyroid problems
- ☐ Smoking
- ☐ Bowel/bladder problems
- ☐ Sudden weight changers
- ☐ Metal implants and/or hardware
- ☐ Coronary artery desease
- ☐ Diabetic ☐ Insulin depend ☐ diet controled

Patient Signature_____

Print and sign.

Next MD visit _____