MALLERS & SWOVERLAND
Your Choice for Results!
Orthopaedic Physical Therapy, LLC

(Please Print) If you need help completing this form, do not hesitate to ask our staff for help.

Patient's Name_____SSN _____Date Of Birth_____ Sex O Male O Female
Last First MI

Address: _____
Street City State Zip

E-mail_____ **Would you like to receive our monthly email newsletter?** Yes No

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: **(circle one)** Single / Married / Other Patient Status : **(circle one)** Employed Full-Time / Employed Part-Time / Student / Retired / Disabled

Patient's Employer: _____Work Phone: _____

Emergency Contact: Name: _____Relationship:_____Phone: _____

Family Doctor:_____

PATIENT INSURANCE INFORMATION - PLEASE BRING YOUR INSURANCE CARD/ID

Primary Insurance Company: _____

Name of Insured: _____Date of Birth: _____ SSN: _____

Relationship to Insured: (circle one) Self / Spouse / Child / Other Employer:_____ Work Phone:_____

Secondary Insurance Company (If Applicable): _____

Name of Insured: _____ Date of Birth: _____ SSN: _____

Relationship to Insured: (circle one) Spouse / Child / Other Employer: _____Work Phone:_____

GUARANTOR OF MINOR

Name: _____ Home Phone: _____Cell Phone: _____Work/other:_____
Last First MI

Mailing Address: _____
City State Zip Code

SSN: _____ Date of Birth:_____ Employer: _____

AUTO LIABILITY INFORMATION – WE ONLY FILE PATIENT' AUTO MED PAY/ NOT other party's insurance/3rd party liability.

Patient's Auto Med Pay Insurance Company:_____Policy Claim#_____ Date of Accident:_____

Claims Address_____Adjuster Name:_____Phone:_____

Is an Attorney involved? (Circle) YES / NO If Yes, Attorney Name:_____ Phone:_____

I understand I have the right to choose my physical therapy provider and have chosen Mallers & Swoverland Ortho PT and hereby authorize and give my consent for MSOPT to furnish physical therapy care and treatment deemed necessary or advisable in evaluating or treating my physical condition. I further authorize the release of any medical information to process insurance claims and further authorize payment of medical benefits to MSOPT for my claims filed with insurance when & if applicable.

*Signature:*_____ *Date:*_____

PATIENT HISTORY QUESTIONNAIRE

Patient name: _____

1. What is your primary problem? _____

_____

2. How did your problem begin? _____

3. What date did your problem begin? _____

4. Have you had anything similar before? YES / NO; If YES, describe _____

_____

5. Were you free of symptoms before this onset? YES / NO _____

6. What, if any, treatment have you had for this current problem? _____

_____ Did it help? YES / NO

7. On a scale of 0-10, 10(emergency room-type pain), 0 (no pain), please rate your pain level:

RIGHT NOW:_____ **BEST:**_____ **WORST:**_____

8. On a functional scale of 0-100% (100% is normal), where do you feel you are functioning? _____

9. Is your pain: **CONSTANT**_____ **INTERMITTENT** _____ **CONTINUOUS**_____
(does not change with activity) _____ (changes with activity)_____

10. Do you experience pain, tingling, or numbness traveling beyond the area of dysfunction? YES / NO
If YES, where? _____

11. When is your pain level the least? _____

12. What makes the pain worse? _____

13. Have you had a fall within the last year? _____

14. What are your goals or expectations from receiving physical therapy? _____

If this is a work-related injury, would you like us to inform your family doctor and send him/her your initial evaluation?
YES____ **NO**____ **If YES, Doctor's Name**_____

PERSONAL MEDICAL HISTORY

1. Do you have any of the following problems? (check if YES):

___ Lumps, Growths, or Tumors
___ High Blood Pressure
___ Low Blood Pressure
___ Gallbladder Condition
___ Respiratory/Lung Condition
___ Epilepsy or Convulsive Condition
___ Diabetes or Hypoglycemia
___ Rheumatism, Arthritis
___ Osteoporosis
___ Ear, Nose Throat, Eye Problems
___ Kidney/Bladder Condition
___ Stomach or Intestine Condition
___ Circulatory/Vascular Condition
___ Recurrent Infections Condition
___ Neurological Condition
___ Skin or Dermatologic Condition
___ Birth Defect or Abnormalities
___ Orthopaedic Surgeries
___ Blood Condition
___ Liver Condition
___ Sinus Condition
___ Cancer
___ Rheumatic Fever
___ Heart Ailment
___ Pacemaker
___ Hernia or Rupture

How did you hear about us? Family Member____ **Friend**____ **Physician**____ **Other**_____

JOB STATUS

1. Are you currently working? YES / NO If Yes describe restrictions, if any: _____

_____

2. If not working, what was the last date of work? _____

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Specialists in
Orthopaedic Manual Therapy

MEDICATION LIST

Name: _____ Date: _____

Medication/Supplements/Vitamins	Dosage	Frequency	Route of Administration (oral, shot, etc.)

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