



(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 Male 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 Mellers & 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 _____

How did you hear about us? Family Member ___ Friend ___ Physician ___ Other _____

PERSONAL MEDICAL HISTORY

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Lumps, Growths, or Tumors | <input type="checkbox"/> Ear, Nose Throat, Eye Problems | <input type="checkbox"/> Blood Condition |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney/Bladder Condition | <input type="checkbox"/> Liver Condition |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stomach or Intestine Condition | <input type="checkbox"/> Sinus Condition |
| <input type="checkbox"/> Gallbladder Condition | <input type="checkbox"/> Circulatory/Vascular Condition | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Respiratory/Lung Condition | <input type="checkbox"/> Recurrent Infections Condition | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Epilepsy or Convulsive Condition | <input type="checkbox"/> Neurological Condition | <input type="checkbox"/> Heart Ailment |
| <input type="checkbox"/> Diabetes or Hypoglycemia | <input type="checkbox"/> Skin or Dermatologic Condition | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Rheumatism, Arthritis | <input type="checkbox"/> Birth Defect or Abnormalities | <input type="checkbox"/> Hernia or Rupture |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Orthopaedic Surgeries | <input type="checkbox"/> Dementia/Alzheimer's |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Depression | |

The Patient Health Questionnaire-2 (PHQ-2)

| Over the past 2 weeks, how often have you been bothered by any of the following problems? | Not At All | Several Days | More Than Half the Days | Nearly Every Day |
|---|------------|--------------|-------------------------|------------------|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |

