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 ○ 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 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_____

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):

___ 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
___Bipolar Disorder
___ 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
___Depression
___ Blood Condition
___ Liver Condition
___ Sinus Condition
___ Cancer
___ Rheumatic Fever
___ Heart Ailment
___ Pacemaker
___Hernia or Rupture
___Dementia/Alzheimer's

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

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Specialists in
Orthopaedic Manual Therapy

MEDICATION LIST

Name: _____ **Date:** _____

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

www.msoptherapy.com

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