

(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 ○ Fema	ıle
Last Address:	First	MI				
Street E-mail_		С	Eity	State Would you like to receive	e Zip 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-Tin	ne / Employed Part-Time / S	Student / Retired / Disabled	
Patient's Employer:					Work Phone:	
Emergency Contact: Name:			Relationship:		Phone:	
Family Doctor:						
	PATIENT INSU	RANCE INFORMATION	- PLEASE BRING YO	UR INSURANCE CARD/ID		
Primary Insurance Company:						
Name of Insured:			D	ate of Birth:	SSN:	
Relationship to Insured: (circle one)	Self / Spouse / Child /	Other Employer:_			Work Phone:	
Secondary Insurance Company (If A	applicable):					
Name of Insured:				Date of Birth:	SSN:	
Relationship to Insured: (circle one) Spouse / Child / Other		Employer: _	Employer:Work Phone:		Work Phone:	
		OUADA	NTOD OF MINOD			
		GUARA	NTOR OF MINOR	0 11 71		
Name:	First	MI	_ Home Phone:	Cell Phone:	Work/other:	
Mailing Address:						
			City	State	·	
SSN:	Date o	of Birth:	Employer:			
AUTO LIABILITY INFORMATIO	N – WE ONLY FILE PA	TIENT' AUTO MED P	PAY/ NOT other par	ty's insurance/3 rd party l	<u>iability</u> .	
Patient's Auto Med Pay Insurance Company:			Policy Claim#		Date of Accident:	
Claims Address				_Adjuster Name:	Phone:	
Is an Attorney involved? (Circle) YE	S / NO If Yes, Attorney	Name:			Phone:	
I understand I have the right to choo physical therapy care and treatment insurance claims and further authoriz	deemed necessary or advis	sable in evaluating or trea	ating my physical condi	tion. I further authorize the rel	and give my consent for MSOPT to furn lease of any medical information to proc	ish ess
Signatura				ı	Data:	

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 _____ Were you free of symptoms before this onset? YES / NO____ 5. What, if any, treatment have you had for this current problem? _____ 6. 7. On a scale of 0-10, 10(emergency room-type pain), 0 (no pain), please rate your pain level: On a functional scale of 0-100% (100% is normal), where do you feel you are functioning? ___ INTERMITTENT _____ Is your pain: CONSTANT_ CONTINUOUS_ (does not change with activity) _ (changes with activity)___ Do you experience pain, tingling, or numbness traveling beyond the area of dysfunction? YES / NO When is your pain level the least? 12. What makes the pain worse? ___ Have you had a fall within the last year? ____ 13. 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 ____ Ear, Nose Throat, Eye Problems **Blood Condition** High Blood Pressure ___ Kidney/Bladder Condition Liver Condition Low Blood Pressure Stomach or Intestine Condition Sinus Condition Gallbladder Condition Circulatory/Vascular Condition Cancer Respiratory/Lung Condition Recurrent Infections Condition Rheumatic Fever Epilepsy or Convulsive Condition Neurological Condition Heart Ailment Diabetes or Hypoglycemia Skin or Dermatologic Condition Pacemaker Rheumatism, Arthritis Birth Defect or Abnormalities Hernia or Rupture

The Patient Health Questionnaire-2 (PHQ-2)

Dementia/Alzheimer's

Orthopaedic Surgeries

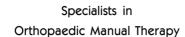
_Depression

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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Osteoporosis

Bipolar Disorder





MEDICATION LIST

Name:	Date:

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

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