COMPLETE CARE PHYSICAL THERAPY

2 LOCATIONS TO SERVE YOU BETTER!

PALM SPRINGS
760.325.5950

RANCHO MIRAGE
760.325.5950

PATIENT INFORMATION			**EMAIL ADDRESS:**
First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	☐ Male ☐ Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -		Spouse:
Chose Clinic Because/ Referred to Clinic By ☐ Dr.:		☐ Insurance Plan ☐ Family ☐ Friend	
☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other:			

WORK INFORMATION		
Employer:	Work Phone ( ) -	Ext.
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION	
Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -

INSURANCE INFORMATION	**(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)**
Primary Insurance Name:	
Subscriber's Name (If different):	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	
Name of Secondary Insurance:	
Subscriber's Name:	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	

AUTO OR WORK INJURY CLAIM		**(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)**	
Insurance Name: ☐ Auto :	☐ Labor & Industries:		
Adjuster/Claim Manager:	Phone:	Ext.:	
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

ATTORNEY INFORMATION			
Name:	Law Firm:	Phone: ( ) -	
Address	City	State:	Zip:

IN CASE OF EMERGENCY		
Name of Local Friend or Relative (Not Living at Same Address):		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

I authorize my insurance benefits be paid directly to Complete Care Physical Therapy. I understand that I am financially responsible for any balance. I also authorize Complete Care Physical Therapy to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE	YES	NO
Hypertension	☐	☐
Low Blood Pressure	☐	☐
Normal Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Myocardial Infarction	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
Do you have a pacemaker	☐	☐

MUSCLE CONDITION	YES	NO
Carpal Tunnel R/L	☐	☐
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity	☐	☐
Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐

OTHER CONDITIONS	YES	NO
Muscular Dystrophy	☐	☐
Rheumatoid Arthritis	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Polio	☐	☐
Dizzy Spells	☐	☐
Impaired Sensation	☐	☐

Other: _____

_____

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day ____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week ____
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week ____
☐ 5+ x Week	☐ Heavy Labor			

What types of exercise do you perform? : _____

What things cause stress in your life? :

Are you taking any seizure medication? ☐YES ☐NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐YES ☐NO If yes list name: _____

List all medications you are currently taking: _____

List all surgeries in the past two years (including dates): _____

Are you pregnant? ☐ YES ☐ NO What week? _____

Have you had any injuries related to work? ☐ YES ☐ NO If yes list body part and date: _____

Have you had any auto accidents? ☐ YES ☐ NO If yes list body part and date: _____

Do you have any metal implanted in your body? ☐ YES ☐ NO If so, please give a description and date implanted.

_____ _____

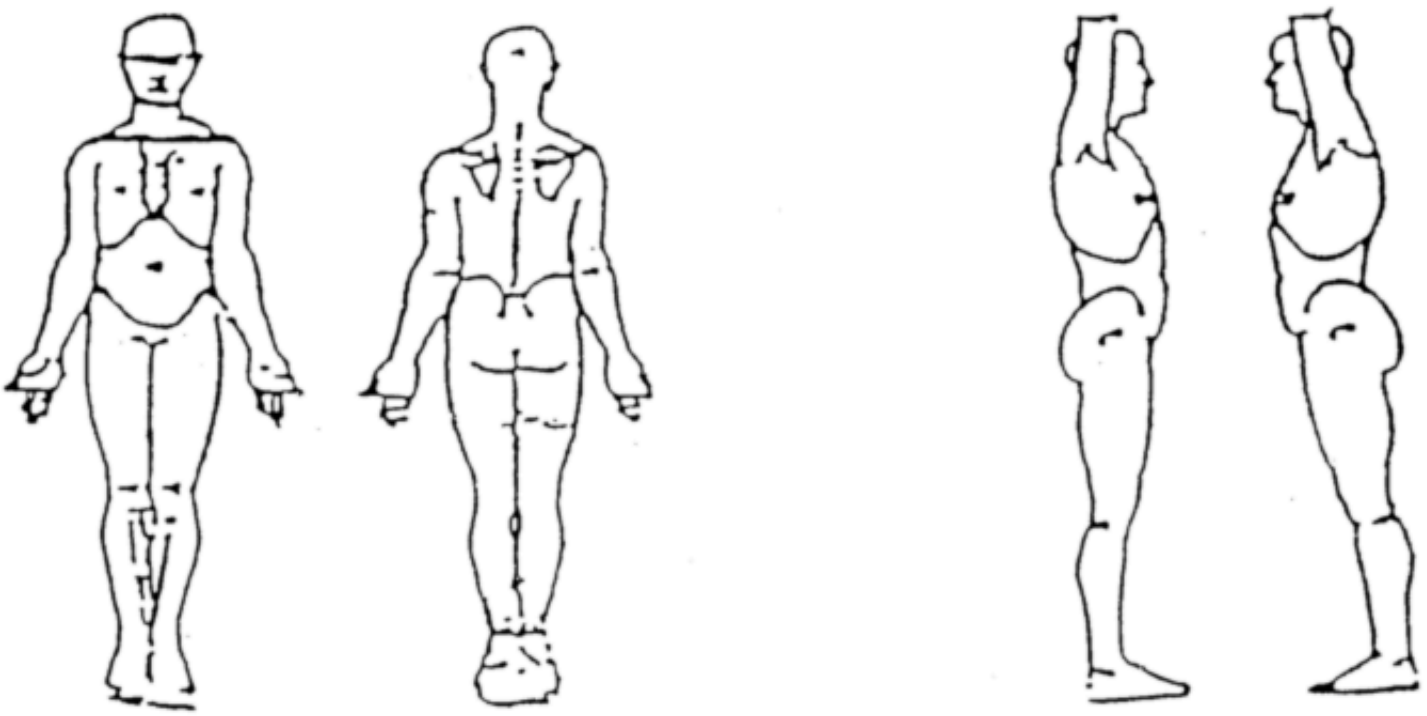
Signature of Patient, Parent, Guardian, Personal Representative Date

Pain Description

1. What problem are you here for today? _____

2. Describe how and when your pain occurred: _____

3. Please mark on the body chart below, your areas of discomfort:



4. Mark on the scale below, the intensity of the discomfort. 0 = no pain and 10 = pain so intense you need to go to the E.R.

0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

5. Please chart how your discomfort changes during the day.

	Morning	Afternoon	Evening
Better			
Worse			

6. Does your pain wake you in the night? □ Yes □ No If yes, how often? _____

7. Which activities increase your symptoms?

□ Sitting □ Walking □ Kneeling □ Twisting □ Standing □ Reaching □ Lifting □ Stairs □ Bending

□ Squatting □ Rising From Chair □ Reclining □ Pushing/Pulling Other: _____

8. What eases your symptoms? □ Heat □ Ice □ Rest □ Medication □ Change in Position Other _____

9. Have you had a similar problem before? _____ If so, when? _____

10. Have you had treatment for this problem before? _____ If so, when, and for how long? _____

11. Is your injury preventing you from participating in recreational activities? _____

12. Rate the physical demands of your recreational activities: _____

13. How is your condition progressing overall? _____