



Today's Date: \_\_\_\_\_

### Patient Information

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Female Male

Marital Status: Single / Married / Divorced / Widowed

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

**Is it okay for us to contact you at the above home phone number and leave messages to you or your household members regarding your appointments at Capitol Physical Therapy? Y / N**

### Insurance Information

#### Primary Insurance Coverage

Insurance CO: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**If you are the policy holder:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Policy ID # \_\_\_\_\_ Group # \_\_\_\_\_

Effective Date: \_\_\_\_\_ Employer: \_\_\_\_\_

**If you are not the policy holder:**

Policy Holder's Name: \_\_\_\_\_ Policy Holder's DOB: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Policy Holder's Employer: \_\_\_\_\_

Policy ID # \_\_\_\_\_ Group # \_\_\_\_\_

#### Secondary Insurance Coverage

Insurance CO: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**If you are the policy holder:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Policy ID # \_\_\_\_\_ Group # \_\_\_\_\_

Effective Date: \_\_\_\_\_ Employer: \_\_\_\_\_

**If you are not the policy holder:**

Policy Holder's Name: \_\_\_\_\_ Policy Holder's DOB: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Policy Holder's Employer: \_\_\_\_\_

Policy ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

### Attorney Information

Check if not applicable

Law Firm: \_\_\_\_\_

Attorney's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

### Medical Information

Referring Doctor: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Date of Onset/Injury: \_\_\_\_\_ Dates of Hospitalization: \_\_\_\_\_

**IS THIS INJURY: WORK RELATED / AUTO RELATED / SCHOOL SPORTS / RECREATIONAL SPORTS / OTHER (CIRCLE ONE)**

**If work or auto related, please fill out this section:**

Auto or Work Related Claim Number: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ When was your last date of work? \_\_\_\_\_

Claims Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Firm: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

### Current Injury/ Disorder Information

What is your injury?

Date of injury?

Please describe how the injury/disorder occurred:

When is your pain the worst? Morning / Afternoon / Evening / Fluctuates / Constant

What activities aggravate the pain/symptoms?

What activities ease the pain/symptoms?

What is your pain level right now?

No Pain \_\_\_\_\_ Worst Imaginable Pain \_\_\_\_\_

1      2      3      4      5      6      7      8      9      10

Is your pain: Dull / Achy / Burning / Tingling / Sharp / Shooting / Numbing / Stabbing

## Medical History

To the best of your knowledge, have you or anyone in your family ever had any of the following conditions?	You	Family Member
Angina/chest pain?	Y / N	Y / N
Broken bones?	Y / N	Y / N
Cancer?	Y / N	Y / N
Diabetes?	Y / N	Y / N
Heart disease/heart attack?	Y / N	Y / N
High blood pressure?	Y / N	Y / N
Osteoarthritis?	Y / N	Y / N
Osteoporosis or Osteopenia?	Y / N	Y / N
Rheumatoid arthritis?	Y / N	Y / N
Stroke?	Y / N	Y / N
Other? _____	Y / N	Y / N

Do you have a history of:	Yes	No	Do you have a history of:	Yes	No
Allergies/Asthma?			Are you depressed?		
Are you pregnant?			Bronchitis?		
Dizziness/Balance problems?			Headaches?		
Hernia?			Kidney disease/problems?		
Metal implants?			Nervous disorders?		
Rheumatic fever?			Pacemaker?		
Seizures?			Sensitive to heat/ice?		
STDs?			Ulcers?		

In the past few months have you experienced:	Yes	No	In the past few months have you experienced:	Yes	No
A change in your health?			Changes in appetite?		
Changes in bowel or bladder functions?			Difficulty swallowing?		
Dizziness?			Fever/chills/sweats?		
Nausea/vomiting?			Numbness or tingling?		
Shortness of breath?			Unexplained weight changes?		
Upper respiratory infection?			Urinary tract infection?		

Are you under stress?	Yes	No	
Are your symptoms getting	Worse	Same	Better
Describe your activity level	Not active	Active	Very Active
Do you have a problem with	Vision	Speech	Hearing
Do you smoke?	No	Yes	____ packs a day
How are you able to sleep	Poor	Fair	Medicated
How do you most effectively learn?	Audio	Visual	Hands-on
How often do you drink alcohol?	Never	Once a week	____ times a week
Date of last medical exam?			
List of medications you are currently using:			

How did you hear about Capitol Physical Therapy?

\_\_\_ Advertisement

\_\_\_ Insurance Co.

\_\_\_ Website

\_\_\_ Co-worker

\_\_\_ Physician

\_\_\_ Other \_\_\_\_\_

\_\_\_ Friend/Family

I have completed the above information to the best of my ability.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_