

JOHN SWEENEY PHYSICAL THERAPY SERVICES

Today's Date: _____
Patient ID #: _____

PATIENT MEDICAL HISTORY & INTAKE FORM

Patient Name: _____ Social Security #: _____ - _____ - _____

Address (City, State, Zip): _____

Date of Birth: ____/____/____

Home #:(____) ____ - _____ Work #:(____) ____ - _____ Cell #:(____) ____ - _____

E-Mail Address: _____

Sex: Male Female Are you: Right-handed Left-handed Height: _____ Weight: _____ lbs

Emergency Contact (Name): _____

Relationship: _____ Phone #:(____) ____ - _____

Contact Info (Address, City, Zip): _____

Primary Care Physician: _____ Phone #:(____) ____ - _____

Contact Info (Address, City, Zip): _____

Who Referred You (Name): _____

Relationship: _____ Phone #:(____) ____ - _____

Contact Info (Address, City, Zip): _____

Insurance Company: _____

Address (City, State, Zip): _____

Policy/ ID #/ Claim #: _____ Group #: _____

Telephone #: (____) ____ - _____

Date of injury/onset: ____/____/____ Have you ever had these symptoms before? Yes No

Check which apply to your symptoms:

- Work related injury
- Injury related to lifting
- Athletic/Recreational Injury
- Recurrence of previous injury
- Injury related to falling
- Other: _____
- Motor vehicle accident
- Cause unknown

IF CAUSE IS KNOWN, PLEASE EXPLAIN: _____

Current Condition(s)/Chief Complaint(s)

How are you taking care of the problem(s) now?

What makes the problem(s) better?

What makes the problem(s) worse?

What are your goals for physical therapy?

Authorization: _____ Verified By: _____.

Authorized By: _____.

Claim Rep. Name

Co Payment Amount: _____.

Authorization Number: _____.

Effective Date: _____.

Terminate Date: _____.

A/A or W/C Open Claim Verification: _____.

Attorney Information: _____

_____.

Consent

For Medicare patient's only:

I request that the payment of authorized medical benefits be made on my behalf to John Sweeney Physical Therapy Services (JSPTS) for any services furnished to me by the physical therapist. I authorize any holder of medical information about me to release it to the Health Care Financing Administration and its agents and information needed to determine these benefits payable to related services.

I have read and understood the above statement.

Signature of patient/guarantor

Date

For Non-Medicare patient's only:

I hereby authorize John Sweeney Physical Therapy Services (JSPTS) furnish information to my insurance carrier concerning my treatment in order to receive payment. I also authorize JSPTS to furnish my physician with information relevant to my treatment. I assign JSPTS direct payment of services rendered. If I receive payment from the insurance company for services rendered by JSPTS agree to reimburse JSPTS in full at the time of receipt of payment. I understand that I am financially responsible for any amount not covered by my insurance carrier(s)/Medicare.

Signature of patient/guarantor

Date

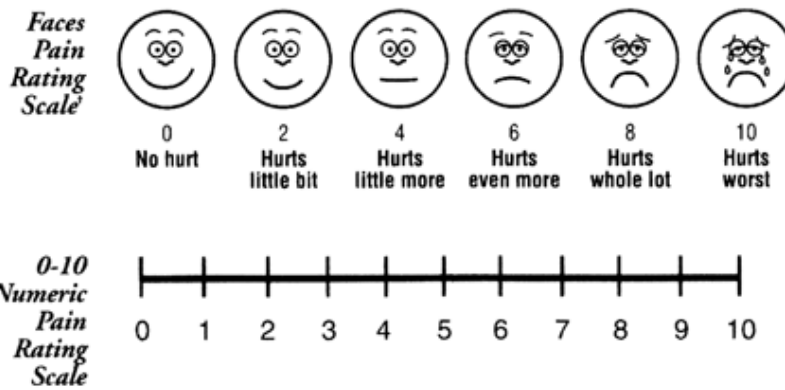
Medications

Do you take any medications? Yes No

If yes, please list what medications and for what condition:


Are you **ALLERGIC** to any medications? Yes No If Yes, please list:

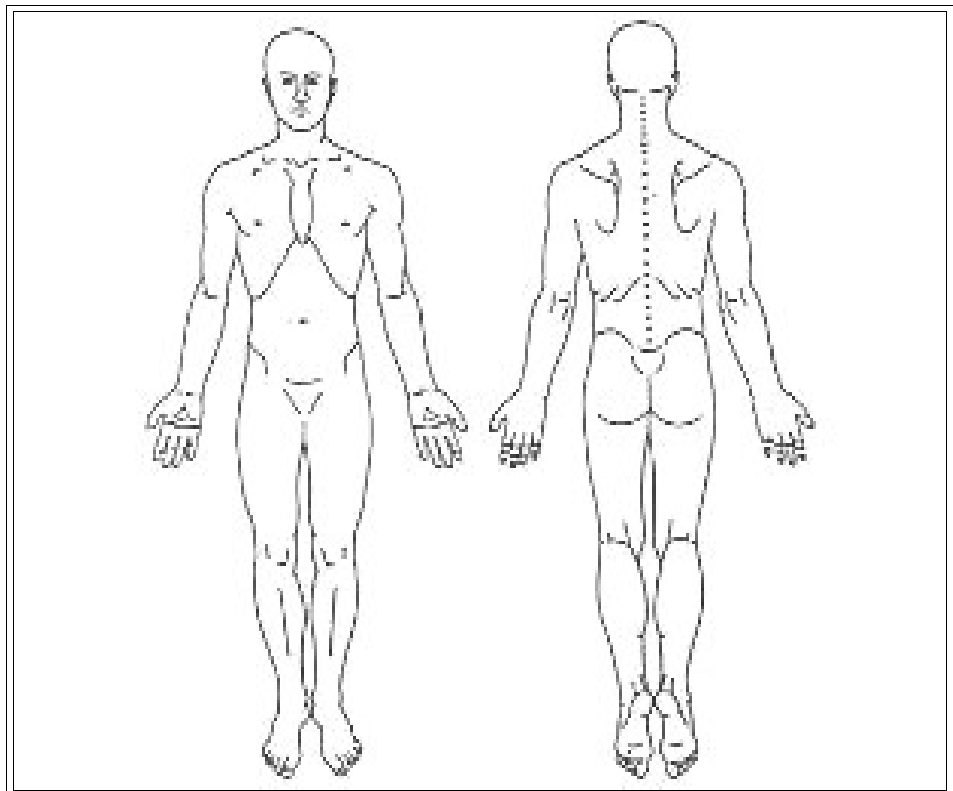
Rate Your Pain Level:



Check your symptoms:

Please indicate below where your symptoms are located

Key:
Numbness 
Pins & Needles oooooo
Burning Pain XXXXXXXX
Stabbing Pain //////////////



1. With whom do you live:

- Alone
- Spouse Only
- Spouse and other(s)
- Child (not spouse)
- Other relative(s) (not spouse or children)
- Group Setting
- Personal Care Attendant
- Other

2. Have you completed an advance directive? Yes No

3. Employment/Work (Job/School/Play)

- Working full-time outside home
- Working full-time at home
- Working part-time outside home
- Working part-time from home
- Homemaker Student Retired Unemployed

Occupation: _____

Company Name/Address/Phone

Number: _____

Living Environment

4. Does your home have:

- Stairs, no railing
- Stairs, railing
- Ramps
- Elevator
- Uneven Terrain
- Assistive Devices (eg, bathroom): _____
- Other: _____
- Any Obstacles: _____

5. Do you use:

- Cane
- Walker or rollator
- Manual Wheelchair
- Motorized Wheelchair
- Glasses, hearing aids

6. Where do you live:

- Private Home
- Private Apartment
- Rented Room
- Board and care/assisted living/group home
- Homeless (with or without shelter)
- Long-term care facility (nursing home)
- Hospice
- Other: _____

7. General Health Status Please

Rate your Health:

- Excellent Good Fair Poor

Have you had any major life changes during past year? (eg. New baby, job change, death of family member) Yes No

Is your current weight stable? Yes No

If not, please explain: _____

8. Social/Health Habits

a. Smoking

1. Currently smoke tobacco?

- Yes
 - Cigarettes: # packs per day _____
 - Cigars/Pipes: # per day _____
- No

2. Smoked in Past? Yes Year Quit: No

b. Alcohol

1) How many days per week do you drink beer, wine or other alcoholic beverages, on average?

2) If 1 beer, 1 glass of wine, or 1 cocktail equals 1 drink, how many drinks do you have on an average day?

c. Exercise

Do you exercise beyond normal daily activities and chores?

- No Yes, Describe the exercise: _____

On average, how many days per week do you exercise or do physical activity? _____

For how many minutes, on an average day? _____

9. Social History

Any customs or religious beliefs or wishes that might affect care?

10. Family History (Indicate whether mother, father, brother/sister, aunt/uncle, or grandmother/grandfather, and age of onset if known)

Heart Disease: _____

Hypertension: _____

Stroke: _____

Diabetes: _____

Cancer: _____

Psychological: _____

Arthritis: _____

Osteoporosis: _____

Other: _____

11. Medical/Surgical History

Please check if you have ever had:

- Arthritis Multiple sclerosis
- Broken bones/ fractures Muscular dystrophy
- Osteoporosis Parkinson Disease
- Blood disorders Allergies
- Circulation/ Developmental or

vascular problems

growth problems

Heart Problems

Thyroid Problems

High Blood Pressure

Cancer

Lung Problems

Infectious

Stroke

Kidney Problems

Diabetes/high blood sugar

Skin Diseases

Ulcers/stomach problem

Depression

Hypoglycemia

Head Injury

Other: _____

Have you ever had surgery? Yes No

If yes, please describe, and include dates:

_____ Month _____ Year _____

_____ Month _____ Year _____

_____ Month _____ Year _____

For men only: Have you been diagnosed with prostate disease?

Yes No

For women only:

Have you been diagnosed with:

Pelvic Inflammatory Disease? Yes No

Endometriosis? Yes No

Trouble with your period? Yes No

Complicated pregnancies/deliveries? Yes No

Pregnant, or think you might be? Yes No

Other gynecological or obstetrical difficulties? Yes No, if yes, please describe _____

Are you seeing anyone else for the problem(s)? (check all that apply)

Acupuncturist

Cardiologist

Chiropractor

Dentist

Family

Practitioner

Massage Therapist

Neurologist

Internist

Occupational Therapist

Orthopedist

Osteopath

Pediatrician

Podiatrist

Rheumatologist

Obstetrician/gynecologist

Primary Care Physician

Other: _____

12. Functional Status/Activity Level (Check all that apply)

Difficulty with locomotion/movement:

Bed mobility

Transfers (such as moving from bed to chair, from bed to commode)

Gait (walking)

On level

On ramps

On stairs

On uneven terrain

Difficulty with self-care (such as bathing, dressing, eating, toileting)

Difficulty with home management (such as household chores, shopping, driving/transportation, care of dependents)

Difficulty with community and work activities/integration

Work/school

Recreation or play activity

13. Other clinical tests

Within the past year, have you had any of the following tests? (check all that apply)

Angiogram

Arthroscopy

Biopsy

Blood tests

Bone scan

Bronchoscopy

CT Scan

Doppler Ultrasound

Echocardiogram

EEG

EKG

EMG

Mammogram

MRI

Myelogram

NCV

Pap smear

Pulmonary Function Test

Spinal Tap

Stool tests

Stress test

Urine Tests

X-rays

Other: _____