Optimal Care Physical Therapy, PC

Please fill out all applicable fields

Patient Information

Name: ________________________________ Date of Birth: _____/_____/______ SS #: _______________

Parent/Guardian (*if applicable*):____

Address:_____________________________ City :________________________ State: _____ Zip:________

Phone (H): __________________________ (W):________________________ (C):____________________

Race: ( )American Indian/ Alaska Native ( ) Asian ( ) Black/ African American

( ) Hawaiian/ Pacific Islander ( ) White ( ) Other ( ) Decline

Ethnicity: ( )Hispanic or Latino ( )Not Hispanic or Latino ( )Declined

Language: ___________________________

Marital Status: ( )Single ( ) Married ( )Divorced ( )Widowed

E-Mail Address: ____

Employer:____________________________ Occupation:____

Emergency contact: ________________ Phone:_________________ Relationship:__________________

What are you being seen for today:____

Primary Care Physician: __________________ Referring Doctor:_________________________

Phone:______________________ Phone:_____________________

The information above is correct to the best of my knowledge.

Signature:____ Date:___________________

Insurance Information

Please fill out all applicable fields

Name: ___________________________________ Date of Birth: _____/_____/______

Injury related to: ( ) Car Accident ( ) Work Injury ( ) Neither

Insurance Information - Primary

Policy Holder Name:__________________________ Date of Birth:____/_______/___ SS #:________________

Address:_______________________________ City:_________________________ State:_____ Zip:________

Insurance Company:______________________ Member/Subscriber ID:_______________________________

Insured's Employer: ______________________ City:_________________________ State:_____ Zip:________

Insurance Information - Secondary

Policy Holder Name:__________________________ Date of Birth:____/______/___ SS #:________________

Address:_______________________________ City:_________________________ State:_____ Zip:________

Insurance Company:______________________ Member/Subscriber ID:_____________________________

Insured's Employer:______________________ City:_________________________ State:_____ Zip:________

No Fault or Workers comp

Insurance company:________________________ Date of accident:_______________________

Claim number:_______________________ Adjuster Information:____________________________

Phone number:_______________________

Name: ____ Date: ________________

Last First MI

Please describe your current symptoms: ____

____

What date did your symptoms/injury begin?________________ Surgery date:______________________

Is this a result of a motor vehicle accident? (Yes) (No) **Work related injury?** (Yes) (No)

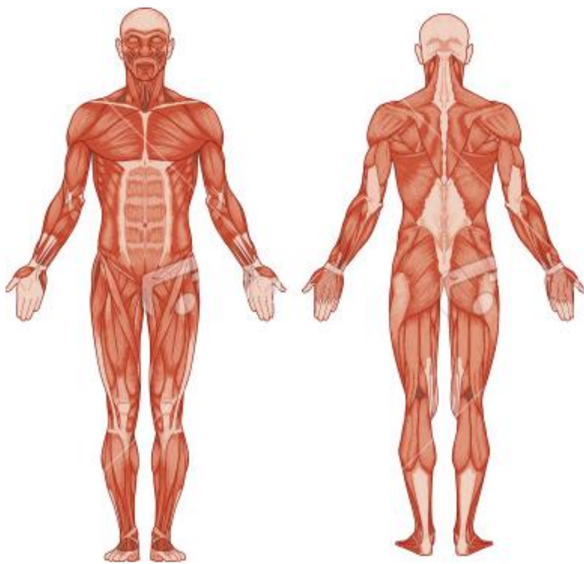
What was the initial cause of your symptoms? ______________________________________

Have you ever experienced these symptoms before? ________________________________

What makes your symptoms worse? ____

What makes your symptoms better? ____

Please indicate on the illustration below where the symptoms/pain occurs:



Severity – At Rest										
0	1	2	3	4	5	6	7	8	9	10
(None)										(Max)

Severity – During Activity										
0	1	2	3	4	5	6	7	8	9	10
(None)										(Max)

How much do your symptoms interfere with your activities?

- ☐ None (1-20%)
- ☐ Rarely (20-40%)
- ☐ Often (40-60%)
- ☐ Most of the time (60-80%)
- ☐ Always (80-100%)

Are you having difficulty with any of the following?

- ☐ Bed Mobility
- ☐ Transfers (ex. Chair to stand)
- ☐ Walking
  - On level ground
  - On stairs
  - Uneven Terrain
- ☐ Self Care (ex. dressing, bathing, eating)
- ☐ Driving
- ☐ Household chores
- ☐ Work/school related activity

Name: ____ Date: ____________________

Last First MI

When your last physical exam? ______________

Physician's Name: ______________

Past hospitalizations and surgeries: ______________

Current medications: ______________

List any allergies (including medications) that you have: ______________

Do you smoke? Y / N

Have you smoked in the past? Y / N

Do you use alcohol? Y / N How often? __________

On average, how many days a week do you exercise? _____

How many minutes, on average, a day? ______________

Within the past year, have you had any of the following?

☐ Arthritis	☐ Multiple Sclerosis
☐ Broken Bones/fractures	☐ Muscular Dystrophy
☐ Head injury	☐ Parkinson's disease
☐ Osteoporosis	☐ Seizures/Epilepsy
☐ Blood disorders	☐ Allergies
☐ Circulation/vascular problems	☐ Developmental or growth problems
☐ Heart Problems	☐ Thyroid problems
☐ High blood pressure	☐ Cancer
☐ Stroke	☐ Infectious disease
☐ Diabetes/high blood sugar	☐ Kidney problems
☐ Low blood sugar	☐ Skin diseases

☐ Weight Loss or Gain	☐ Coughing up blood	☐ Muscle weakness
☐ Fevers	☐ Shortness of breath	☐ Joint pains/swelling
☐ Trouble Sleeping	☐ Chronic cough	☐ Clot in leg vein
☐ Chronic Fatigue	☐ Blood clot in the lungs	☐ Frequent headaches
☐ Excessive bleeding	☐ Painful breathing	☐ Dizziness
☐ Easy bruising	☐ Wheezing	☐ Seizures
☐ Abnormal Thirst	☐ Chest pain	☐ Numbness
☐ Itchy, red eyes	☐ Irregular heart beat	☐ Trouble walking
☐ Vision problems	☐ Ankle/Hand swelling	☐ Fainting spells
☐ Ear pain	☐ Frequent diarrhea	☐ Acne
☐ Ringing in ears	☐ Constipation	☐ Unwanted hair growth
☐ Hearing loss	☐ Bloody stool	☐ Unusual lump or growth
☐ Sinus problems	☐ Nausea/Vomiting	☐ Dry skin
☐ Nose bleeds	☐ Hemorrhoids	☐ Anxiety
☐ Sore throat	☐ Incomplete urination	☐ Depression
☐ Mouth sores	☐ Painful urination	
☐ Dental Problems	☐ Bloody urine	