

MALLERS & SWOVERLAND PHYSICAL THERAPY, LLC

1st PT Date: _____ Diagnosis: _____ Ref. Phys: _____ Doctor Recheck Date & Location: _____

Patient

Last Name: _____ First Name: _____ M.I. _____ Date of Birth: _____

SSN: _____ Sex: Male Female Age: _____ Marital Status: M ___ S ___ D ___ W ___

Home Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____

If child, Guarantors Name _____ Guarantors Address _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Family Doctor: _____ Address: _____ Office Ph: _____

Are you taking any medications? _____

Reason For Visit/Type of Injury: Job Related Auto Accident Liability Situation Sports Other

Date Of Onset / Injury: _____ Body Part Being Treated: _____

Explanation: _____

EMPLOYMENT INFORMATION

Employer _____ Occupation _____ Phone _____

Circle Status: FT, PT, Unemployed, Disabled, Retired, Student

Address _____ City _____ State _____ Zip _____

Is this Workers's Compensation? (Circle) YES or NO If Yes, Employer Contact: _____

Work Comp Claim#: _____ Case Manager: _____ Phone _____

Work Comp Insurance: _____ Address: _____

W/C Insurance Phone: _____ Claims Adjuster: _____ Phone _____

INSURANCE INFORMATION – (If Not Workman's Comp Or Liability)

Primary Insurance Company: _____ Phone: _____ Effective Date: _____

Name of Insured: _____ Insured's Employer _____ Occupation: _____

InsuredID# _____ PolicyGroup# _____ Insured's SSN: _____ Date of Birth: _____

Claims Mailing Address: _____

Secondary Insurance Company: _____ Phone: _____ Effective Date: _____

If Medicare is Secondary Reason: working aged benefit __, disabled benefit __, veterans admin __, work comp __, public health __

If other __ explain _____

Name of Insured: _____ Insured's Employer _____ Occupation: _____

Insured ID# _____ PolicyGroup# _____ Insured's SSN: _____ Date of Birth: _____

Relationship to Patient: _____ Claims Mailing Address: _____

LIABILITY INFORMATION –(If Not Workman's Comp) We **do not file** with the other party's insurance/3rd party liability.

Patient's Auto Med Pay Insurance: _____ Policy # _____

Claims Address _____ Adjuster _____ Phone _____

Did you open a claim with **YOUR AUTO INSURANCE MED PAY?** (Circle) YES or NO –Claim # _____

Is an Attorney involved?(Circle) YES or NO – Name of Attorney (if applicable): _____

Attorney Address: _____ Attorney Phone _____

Liability Responsible Party (ie: where you fell/or injured) _____ Phone _____

We will give you the bills to file with your insurance or to give to your attorney. If they are not paid in a timely manner by the insurance company, we will expect prompt payment from you in full once discharged..

I authorize the release of any medical information to process insurance claims and further authorize payment of medical benefits to Mallerys & Swoverland Orthopaedic Physical Therapy, LLC in the event they file for insurance.

Authorized Signature: _____ **Date:** _____

PATIENT HISTORY QUESTIONNAIRE

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 _____

5. Were you free of symptoms before this onset? YES / NO _____
6. What, if any, treatment have you had for this current problem? _____
_____ Did it help? YES / NO
7. On a scale of 0-10, 10(emergency room-type pain), 0 (no pain), please rate your pain level:
RIGHT NOW: _____ **BEST:** _____ **WORST:** _____
8. On a functional scale of 0-100% (100% is normal), where do you feel you are functioning? _____
9. Is your pain: **CONSTANT** _____ **INTERMITTENT** _____ **CONTINUOUS** _____
(does not change with activity) (changes with activity)
10. Do you experience pain, tingling, or numbness traveling beyond the area of dysfunction? YES / NO
If YES, where? _____
11. When is your pain level the least? _____
12. What makes the pain worse? _____

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 _____

PERSONAL MEDICAL HISTORY

1. Do you have any of the following problems? (check if YES):

<input type="checkbox"/> Lumps, Growths, or Tumors	<input type="checkbox"/> Ear, Nose Throat, Eye Problems	<input type="checkbox"/> Blood Condition
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Kidney/Bladder Condition	<input type="checkbox"/> Liver Condition
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Stomach or Intestine Condition	<input type="checkbox"/> Sinus Condition
<input type="checkbox"/> Gallbladder Condition	<input type="checkbox"/> Circulatory/Vascular Condition	<input type="checkbox"/> Cancer
<input type="checkbox"/> Respiratory/Lung Condition	<input type="checkbox"/> Recurrent Infections Condition	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Epilepsy or Convulsive Condition	<input type="checkbox"/> Neurological Condition	<input type="checkbox"/> Heart Ailment
<input type="checkbox"/> Diabetes or Hypoglycemia	<input type="checkbox"/> Skin or Dermatologic Condition	<input type="checkbox"/> Hernia or Rupture
<input type="checkbox"/> Rheumatism, Arthritis	<input type="checkbox"/> Birth Defect or Abnormalities	

JOB STATUS

1. Are you currently working? YES / NO Describe restrictions, if any: _____

2. If not working, what was the last date of work? _____
3. What are your goals or expectations from receiving physical therapy? _____