BABINPT
PHYSICAL THERAPY
BETTER QUALITY OF LIFE

PATIENT INFORMATION

Name_____Birthdate_____Age_____SS#_____

Address_____
Street City State Zip

Home Phone_____ Cell Phone_____ Email_____

Marital Status: Single Married Divorced Widowed Other Occupation: _____

Emergency Contact_____ Phone #_____ Relationship_____

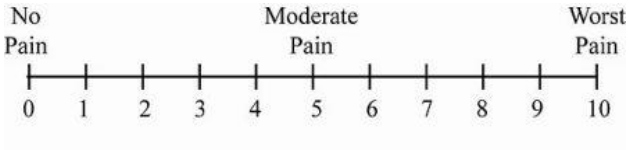
How did you hear about our clinic?

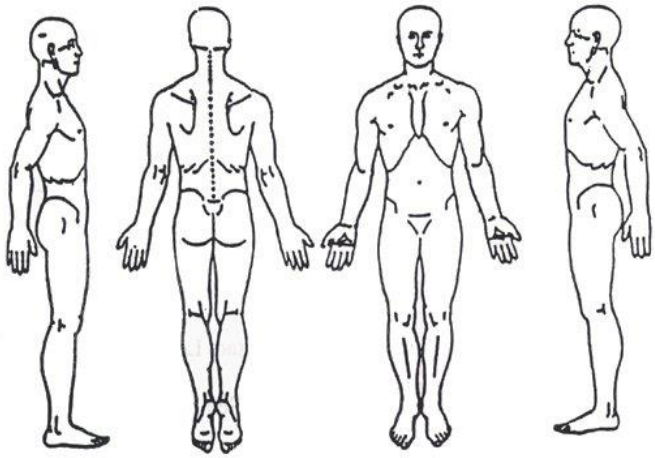
□ My doctor's office □ I am a former patient □ Family/friend/colleague recommended □ My insurance company said you were in my network □ I did a search on the internet □ My trainer □ Other_____

Please tell us who we can thank for sending you our way:_____

REVIEW OF SYMPTOMS

With a highlighter, please mark how intense your pain has been on the scale below. Then, indicate where you have symptoms or pain on the body model.





How often do you experience your symptoms?

1. Constantly (76-100% of the day)
2. Frequently (51-75% of the day)
3. Occasionally (26-50%)
4. Intermittently (0-25%)
5. No Symptoms

What describes your Pain?

1. Sharp 4.Shooting 7. N/A
2. Dull 5.Burning
3. Numb 6.Tingling

How are your symptoms changing?

1. Getting Better 2. Not Changing 3. Getting Worse

Please describe the problem / condition that brought you to therapy:

_____

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How did your problem / condition begin? (Circle one): Date your condition began: _____

Injury Sudden Onset Gradually Post Operation Motor Vehicle Accident Other: _____

Who have you seen for your symptoms? (Circle all that apply):

No One Medical Doctor Chiropractor Home Health Massage Therapist PT Other: _____

What are you most hoping to get out of your therapy / activities you would like to return to:

_____

Do you now or have you ever had any of the following? (Circle all that apply) NONE APPLY

Asthma, Bronchitis, or Emphysema High Blood Pressure Anemia Shortness of Breath/Chest Pain

Heart Attack or Surgery Diabetes Coronary Heart Disease or Angina Thyroid Trouble/Goiter

Gout Cancer/chemotherapy/Radiation Dizziness or Fainting Weakness Mental Health Problems

Infectious Diseases Hernia Bowel or Bladder Problems Allergies Severe or Frequent Headaches

Elbow/Hand Injury Osteoporosis Vision or Hearing Difficulties Neck Injury/Surgery Stroke/TIA

Sleeping Problems/Difficulties Back Injury/Surgery Blood Clot/Emboli Leg/Ankle/Foot Injury/Surgery

Knee Injury/Surgery Epilepsy/Seizures Arthritis/Swollen Joints Varicose Veins Joint Replacement

Do you have a Pacemaker? YES/NO **Any Pins or Metal Implants?** YES/NO **Do You Smoke?** YES/NO
Females: **Are You Pregnant?** YES/NO
Explanations (If needed): _____

SURGERIES (LIST PROCEDURE AND YEAR):
Body Region:_____ Surgery Type: _____ Date:_____
Body Region:_____ Surgery Type: _____ Date:_____
Body Region:_____ Surgery Type: _____ Date:_____

Are you currently taking any medications? Y / N If yes: Is list attached Y/N OR please list below:
Medication_____ Dosage_____ Reason for taking: _____
Medication_____ Dosage_____ Reason for taking: _____
Medication_____ Dosage_____ Reason for taking _____
Allergies (Medications and Others): _____

I acknowledge that the above information is true and correct. I hereby authorize treatment and understand the possible benefits and risks of my treatment. I irrevocably assign all benefits to Babin Physical Therapy. I authorize release of any medical records to my doctor, insurance company, attorney, claims adjuster and my employer. I also authorize release of any physician or medical facility to release information relevant to Babin Physical therapy. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services. I further understand and agree to pay for all fees incurred should this bill be turned over to an agency or attorney for collection.

Signature_____ Date_____