body mechanics

comprehensive
orthopedic
physical
therapy

Patient Information

Today's Date

Please print and bring to your first appointment

Name				Date of INJURY			
Address				Birth date			
City		State		Zip		Home Phone	
E-mail				Work Phone			
Cell Phone				Injury Area			
In case of emergency, contact				Phone			
Family Physician				Referring Physician for Therapy			

Insurance Information

Please provide insurance card for us to copy

Policyholder		Address			
Employer		Policyholder's Signature			
Date of birth for policyholde		Relationship to patient			
Group name/number		Insurance ID #			
Date of Injury					
Insurance Name		Address			
Insurance Phone #					
Co-pay or percentage		Deductible		Met for the year?	☐

Worker's Compensation Information

Worker's Comp. Claim #		Date of Injury	
Adjuster's name		Adjuster's phone #	
Billing address			
Workplace contact person		Phone #	
Adjuster's Fax #		Patient's Social Security Number	

Body Mechanics Physical Therapy, Patient Information p. 2
Medical History

Primary physical problem _____

Date of onset/accident (**Note**: You must put a date here to ensure insurance payment.) _____

Have you had any radiographs (X-rays), CT scan or MRI reports? _____
Results? _____

Please list your current medications: *(Include inhalers and birth control pills)*

What health measures have you taken?

Please describe your general diet, water and vitamin/supplement intake:

What, if any, techniques do you use for relaxation?

Please provide any additional information you believe to be important for your physical therapy:

Do you have or have you previously had:

		Please Explain: when & where?		
Arthritis	Yes ☐		No	☐
Broken bones	Yes ☐		No	☐
Joint pain	Yes ☐		No	☐
Osteoporosis	Yes ☐		No	☐
Severe sprains	Yes ☐		No	☐
Recent weight loss/gain	Yes ☐		No	☐
Radiating pain in limbs	Yes ☐		No	☐
Numbness or tingling	Yes ☐		No	☐
Changes in bowel/bladder	Yes ☐		No	☐
Heart condition	Yes ☐		No	☐
High blood pressure	Yes ☐		No	☐
Hemophilia	Yes ☐		No	☐
Pneumonia/asthma or other respiratory problem	Yes ☐		No	☐
Diabetes	Yes ☐		No	☐
Cancer	Yes ☐		No	☐
Cysts or tumors	Yes ☐		No	☐
Anxiety/panic attacks	Yes ☐		No	☐
Loss of breath on exertion	Yes ☐		No	☐
Palpitations/racing heart	Yes ☐		No	☐
Concussions	Yes ☐		No	☐
Passing out/dizziness	Yes ☐		No	☐
Surgery	Yes ☐		No	☐
Pain with cough/sneeze	Yes ☐		No	☐
Are you pregnant?	Yes ☐		No	☐
Are you allergic to latex?	Yes ☐		No	☐
Do you have night pain?	Yes ☐		No	☐