Physical Therapy Admission Questionnaire

Mt. Shasta Physical Therapy
633 Lassen Lane
Mt. Shasta, CA 96067
Tel: 530/926-6010

PATIENT NAME: ____
DATE: ____

PROBLEM:
Main reason for physical therapy):
____
____

Date problem began: ____
Related surgeries and dates:
____
____

If accident, how did it happen? (Please include date of accident.)
____
____

MEDICAL HISTORY:

Do you have any of the following symptoms?

		YES	NO
Pain:	________	___	___
Nausea:	________	___	___
Balance difficulties:	__	___	___
Stiffness:	________	___	___
Dizziness:	________	___	___
Headache:	________	___	___
Swelling:	________	___	___
Weakness:	________	___	___

Do you have any of the following conditions?

		YES	NO
Heart disease:	________	__	__
High blood pressure:	________	__	__
Pregnancy:	________	__	__
Diabetes:	________	__	__
Heart pacemaker:	________	__	__
Open sores:	________	__	__

Other: ______________________

METAL IMPLANTS : ________ **Please describe:**______________________
ALLERGIES: ________ **Please describe:** ______________________

DO YOU HAVE ANY OTHER MEDICAL CONDITION THAT MIGHT BE IMPORTANT TO YOUR PHYSICAL THERAPY TREATMENT? Please describe:
____
____

MEDICATIONS YOU ARE CURRENTLY USING:

Medication:	To treat what?
______________	______________
______________	______________
______________	______________
______________	______________
______________	______________

Please see other side

Medical History continued:

HAVE YOU HAD ANY OF THE FOLLOWING? (Circle if applicable)
X-ray MRI CT scan Myelogram
Results of the tests:

____
____
____

PREVIOUS HOSPITALIZATIONS (Most recent one first) DATE

____
____
____
____

PRIOR PHYSICAL THERAPY:
Reason DATE

____
____

ACTIVITIES/LIFESTYLE
What is your current activity level? (Circle one)
Sedentary Light Moderate Heavy Very heavy
Activity level before current problem: (Circle one)
Sedentary Light Moderate Heavy Very heavy
Activities that you currently find difficult or are unable to do:

____
____

Hobbies and recreational activities:

____

Are you currently working? (Circle one) Yes No
If yes, job description: ____

Do you live alone? Yes __ No __
If yes, do you have help at home? Yes __ No __
Do you have steps or stairs at home? Yes __ No __
If yes, do they have hand railings? Yes __ No __
Have you fallen recently? Yes __ No __

Name/address of doctor, other than you referring physician, where you wish to have your therapy progress notes sent:

____
Name ***Phone Number***
____
Address

WHERE DID YOU HEAR ABOUT MT SHASTA PHYSICAL THERAPY?

____

Mount Shasta Physical Therapy & Wellness Clinic
633 Lassen Lane
Mt. Shasta, CA 96067
Tel: 530-926-6010

FINANCIAL AND CANCELLATION AGREEMENT

"I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read and completed all the information on the patient information sheets. I certify the information I have given is true and correct to the best of my knowledge. I will notify you of any changes in my health status of the above information."

" I understand and agree that, it is necessary to contact Mount Shasta Physical Therapy within 24 hours if I cannot keep an appointment. If no effort is made to cancel an appointment, a service charge (not reimbursable by my insurance) will be made for which I will be responsible."

____ _________________________

Patient signature ***Date***

____

Print Name

____ _________________________

Parent Signature (If patient is a minor) ***Date***

____

Print Name

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AUTHORIZATION FOR ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment for physical therapy services that I am to receive to be paid directly to Mt. Shasta Physical Therapy. I also authorize Mt. Shasta Physical Therapy to release any information required by my insurance company in order to process claims.

Patient Signature: ____ *Date* ________________

PRINTED NAME: ____

(If signed by other than patient, please indicate relationship: ________________________*)*