



Patient Information Form

Thank you for taking the time to complete this information. We value your privacy. All information you provide is confidential and is used solely for direct patient care purposes.

Patient Name: _____

Mailing Address: _____

City: _____ State: _____ ZIP _____

Home phone: _____ Work phone: _____ Cell phone: _____

Date of Birth: _____

Emergency Contact: _____ Phone: _____

Date of injury or onset of symptoms: (Please be as specific as possible.) _____

Are you currently being seen by a physical therapist in your home? yes / no

Primary Insurance Carrier: _____ Name of Primary Insured: _____

Insured's Date of Birth: _____ Relationship to Insured: _____

Secondary Insurance Carrier (if any) _____

Referring Physician: _____ Primary Care Physician: _____

I, the undersigned, agree to assign my insurance benefits to be paid directly to DaVinci Physical Therapy for medical services rendered. I understand that I am financially responsible for all charges, whether paid or not by insurance. I hereby authorize DaVinci Physical Therapy to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submission.

Client Signature: _____

Date: _____

Parent Signature: _____

Date: _____

Current Injury and Health History

Briefly, what problem brings you to physical therapy today? _____

Problem is related to ___work ___home ___sports ___auto accident___other accident___ other.

Have you seen a doctor about this problem? _____ Doctor's name: _____

What medical imaging (i.e., x-ray, MRI, arthrogram, CT scan) has been performed or proposed?

Results: _____ Date of proposed imaging: _____

Have you or are you currently using Prednisone, Cortisone, steroids, or an inhaler? _____

Are you taking any other over-the-counter or prescribed medications for this problem?

Please specify medication and dosage: _____

How long have you been taking this medication? _____

Who recommended or prescribed this medication? _____

Does your pain wake you at night? _____ If yes, can you find a comfortable position and return to sleep? _____

Have you had a similar problem before? _____ Date: _____

Currently the symptoms are: _____Improving _____ Staying the same _____Worsening

Activities that *increase* the symptoms include _____

Activities that *decrease* the symptoms include: _____

Are you able to continue working? _____Full duty _____Light duty _____No

Last day worked: _____

Please rate your ability to perform your daily activities prior to this problem.

0%-----100%

Please rate your ability to perform you daily activities since this problem.

0%-----100%

Have you experienced any of the following with your **current problem** (check applicable)?

Locking		Lip numbness	
Buckling		Unsteady gait	
Dislocating		Headaches	
Loss of Balance		Numbness in groin or buttock area	
Dizziness		Loss of bladder control	
Blurred vision		Numbness in extremities	
Dropping items		Other:	

Have you ever been diagnosed or treated for any of the following (check applicable)?

Cancers		Osteoporosis	
Heart disorder		Allergies	
Stroke		Asthma	
Blood clots		Seizures	
High blood pressure		Concussion	
Arthritis		Headache	
Sprain/strain		Hepatitis	
Whiplash		Diabetes	
Broken bone		Nerve disorders	
Lung Problems		Osteoporosis	
Tuberculosis		Allergies	

What are your goals and expectations for physical therapy? _____

Cancellation Policy

If you need to change or cancel your appointment, we are happy to do that for you—provided that you let us know **24 hours in advance**.

However, if you cancel your appointment with **less than 24 hours notice** or simply fail to show up for your appointment, we will charge you a **\$40 cancellation fee**.

We believe this policy allows you flexibility in scheduling yet is still fair to our therapists. Thank you for your understanding.

Privacy Policy

I acknowledge that I have reviewed the DaVinci Physical Therapy **NOTICE OF PRIVACY PROCEDURES and CANCELLATION POLICY** or that I have received or been offered a copy of the Notice of Privacy Procedures.

 Patient or Personal Representative Signature

 Date

Pain Drawing

Please use the drawings below to indicate where you feel symptoms right now.

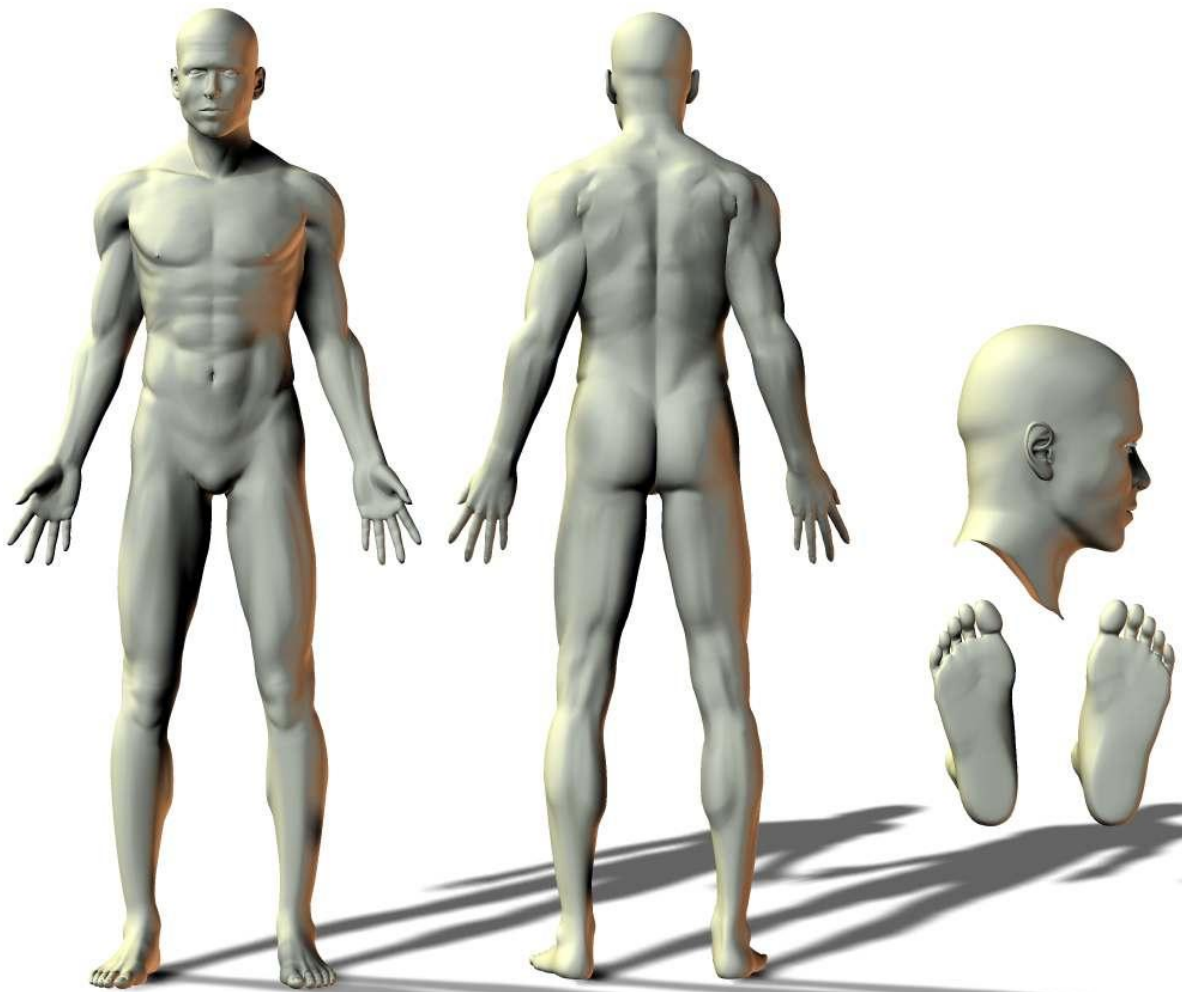
Use the following key to indicate different types of symptoms:

Pins/Needles = 00000

Stabbing = /////

Burning = XXXX

Deep Ache = ZZZZZ



Using the two scales below, please circle the number that most accurately describes the intensity of your pain over the PAST 24 HOURS.

Worst in 24 hours 0 1 2 3 4 5 6 7 8 9 10

Least in 24 hours 0 1 2 3 4 5 6 7 8 9 10