

Initial Evaluation  
 PT \_\_\_\_\_  
 Date \_\_\_\_\_  
 Time \_\_\_\_\_

# 1<sup>st</sup> Choice Physical Therapy

## Patient General Information

Office to be seen in:  
 Algonquin  
 Elgin  
 Huntley  
 Sleepy Hollow

Patient Name: _____ <small style="display: block; text-align: center;">Last Name                      First Name                      Middle Initial</small>			<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB _____ Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> O
Address: _____			SS # _____	
City _____ State _____ Zip _____			E-Mail _____	
Phone: _____			Emergency Contact: _____	
Cell: _____			Phone Number: _____	
Referring Dr. _____ Phone Number _____ Rx Frequency & Duration _____	Reason for PT _____ _____ _____	Injury Type: <input type="checkbox"/> W/C <input type="checkbox"/> MVA <input type="checkbox"/> Other Date of Injury/Accident _____ Surgery Date _____		
Employer _____ Occupation _____ Phone _____	Secondary Reason for PT _____ _____ _____	Comments _____ _____ _____		
How did you hear about 1 <sup>st</sup> Choice Physical Therapy? _____				
Patient Signature _____			Date _____	

*Workers' Comp/Auto Insurance Information—To be filled out by patients who have obtained authorization only*

Workers' Comp Employer/ Auto Insurance being billed _____			
Address _____		City _____ State _____ Zip _____	
Contact _____		Phone _____	
Claim Number _____		Adjuster _____	
Rehab <input type="checkbox"/> Y or <input type="checkbox"/> N	Loss Time: <input type="checkbox"/> Y or <input type="checkbox"/> N	Phone _____	Ext _____
Other Notes _____			

<b>Primary Insurance</b>
Insurance Co. _____ Phone _____ Name on Insurance Card _____ Insured Employer _____ Insured SS Number _____ Group/Site Number _____ ID/Claim Number _____ DOB _____
<input type="checkbox"/> In Network <input type="checkbox"/> Out of Network
Effective Date _____ Deduct \$ _____ Covers _____ Co-Pay _____ Deductible Met <input type="checkbox"/> Yes or <input type="checkbox"/> No Still Owe \$ _____ Out-of-Pocket _____ Include Deduct: <input type="checkbox"/> Y or <input type="checkbox"/> N Calendar Year Max _____ Limited Visits _____
Rx required: <input type="checkbox"/> Y or <input type="checkbox"/> N Referral needed from PCP _____ DME Covered _____ Auth. # required: <input type="checkbox"/> Y or <input type="checkbox"/> N Authorization Phone # _____
Date of Verification _____ By whom _____ Spoke with _____ Notes _____

<b>Secondary Insurance</b>
Insurance Co. _____ Phone _____ Name on Insurance Card _____ Insured Employer _____ Insured SS Number _____ Group/Site Number _____ ID/Claim Number _____ DOB _____
<input type="checkbox"/> In Network <input type="checkbox"/> Out of Network
Effective Date _____ Deduct \$ _____ Covers _____ Co-Pay _____ Deductible Met <input type="checkbox"/> Yes or <input type="checkbox"/> No Still Owe \$ _____ Out-of-Pocket _____ Include Deduct: <input type="checkbox"/> Y or <input type="checkbox"/> N Calendar Year Max _____ Limited Visits _____
Rx required: <input type="checkbox"/> Y or <input type="checkbox"/> N Referral needed from PCP _____ DME Covered _____ Covers Medicare Deductible: <input type="checkbox"/> Yes or <input type="checkbox"/> No Covers 20% Medicare won't: <input type="checkbox"/> Yes or <input type="checkbox"/> No Covers Medicare Denied Codes: <input type="checkbox"/> Yes or <input type="checkbox"/> No
Spoke with _____ Coordination of benefits _____ Notes _____

<i>Front Desk Use Only</i> Dictation Number _____ Date Sent _____ Date Received _____
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# PAST MEDICAL HISTORY FORM

Patient Name \_\_\_\_\_

BLOOD PRESSURE			JOINT CONDITIONS		
	YES	NO		YES	NO
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
Normal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremity Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE			OTHER CONDITIONS		
	YES	NO		YES	NO
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerotic Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
MUSCLE CONDITION			Diabetes		
	YES	NO		YES	NO
Carpal Tunnel R/L	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Tennis Elbow R/L	<input type="checkbox"/>	<input type="checkbox"/>	Poor Eyesight	<input type="checkbox"/>	<input type="checkbox"/>
Back/Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Limited Limb Movement	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
LUNGS			Other:		
	YES	NO	_____		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	_____		

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Low	<input type="checkbox"/> Smoking	Packs a Day _____
<input type="checkbox"/> 1-2 x Week	<input type="checkbox"/> Standing	<input type="checkbox"/> Medium	<input type="checkbox"/> Alcohol	Drinks a Week _____
<input type="checkbox"/> 3-4 x Week	<input type="checkbox"/> Light Labor	<input type="checkbox"/> High	<input type="checkbox"/> Coffee/Soda	Cups a Week _____
<input type="checkbox"/> 5+ x Week	<input type="checkbox"/> Heavy Labor			
What types of exercise do you perform? : _____				
What things cause stress in your life? : _____				

Are you taking any seizure medication?  YES  NO If yes list name: \_\_\_\_\_

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?  
 YES  NO If yes list name: \_\_\_\_\_

List all medications you are currently taking: \_\_\_\_\_

List all surgeries in the past two years (Including dates): \_\_\_\_\_

Are you pregnant?  YES  NO What week?: \_\_\_\_\_

Have you had any injuries related to work?  YES  NO If yes list body part and date.: \_\_\_\_\_

Have you had any Auto Accidents  YES  NO If yes list body part and date.: \_\_\_\_\_

Have you had Physical Therapy or Massage Therapy before?  YES  NO Where: \_\_\_\_\_

Signature of Patient, Parent, Guardian, Personal Representative \_\_\_\_\_

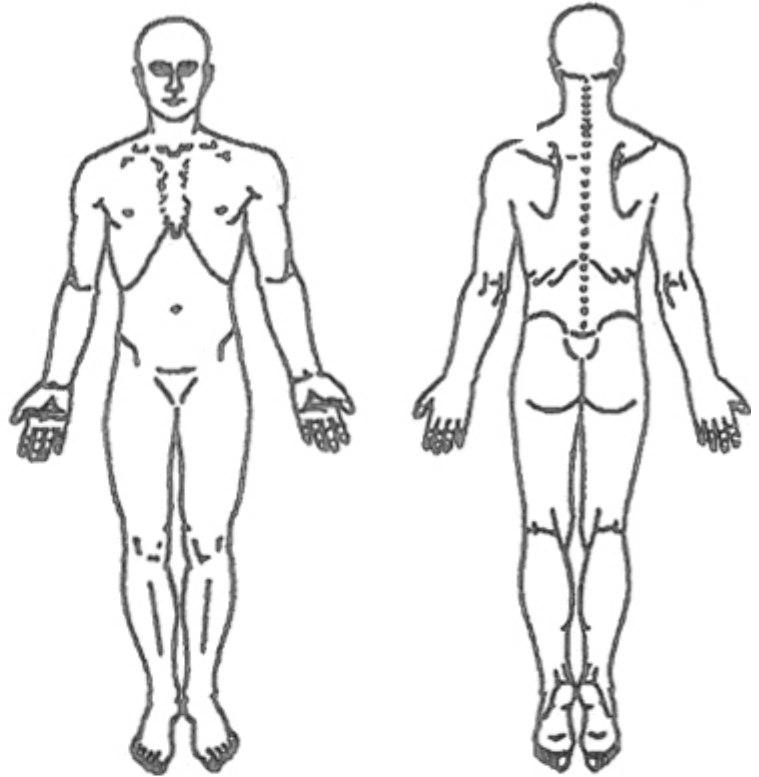
Date \_\_\_\_\_

# Pain and Symptom Status Report

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing



- |   |                              |                                |
|---|------------------------------|--------------------------------|
| <b>Ache</b><br>MMM<br>M                         | <b>Burning</b><br>---<br>--- | <b>Numbness</b><br>OOOO<br>OOO |
| <b>Pins and Needles</b><br>□□□□□□□□<br>□□□□□□□□ | <b>Stabbing</b><br>/////     | <b>Other</b><br>xxxx<br>xxx    |

## Chief Complaint and Visual Analog Scale

My Chief Complaint is: \_\_\_\_\_

Date First Symptom of your problem occurred on: \_\_\_\_\_

2nd Complaint: \_\_\_\_\_

3rd Complaint: \_\_\_\_\_

**Please circle on the scale below to indicate your CURRENT level of pain:**

**No Pain    0    1    2    3    4    5    6    7    8    9    10    Pain as bad as it gets.**

**Please circle on the scale below to indicate your AVERAGE level of pain:**

**No Pain    0    1    2    3    4    5    6    7    8    9    10    Pain as bad as it gets.**

**Please circle on the scale below to indicate your WORST level of pain:**

**No Pain    0    1    2    3    4    5    6    7    8    9    10    Pain as bad as it gets.**

Additional Comments: \_\_\_\_\_