DYNAMIC
Physical Therapy

GENERAL PATIENT INFORMATION

_____ _____ (_____)_____
PATIENT'S LAST NAME PATIENT'S FIRST NAME HOME PHONE

_____ _____ _____
CURRENT STREET ADDRESS CITY ZIP CODE

_____-_____-_____ _____/_____/_____ Sex: M F (_____)_____
SOCIAL SECURITY # DATE OF BIRTH CELL PHONE

_____ _____/_____/_____
REFERRING DOCTOR DATE OF INJURY

_____ (_____)_____ _____
ATTORNEY NAME ATTORNEY PHONE # ATTORNEY ADDRESS

Patient's Primary Language: _____ Interpreter Needed (circle): Yes No

ADDITIONAL INFORMATION

_____ _____ (_____)_____
EMPLOYER EMERGENCY CONTACT PERSON EMERGENCY PHONE

_____ _____ (_____)_____
PRIMARY INSURANCE COMPANY POLICY/GROUP # INSURANCE PHONE #

_____ _____ _____ _____
INSURNACE ADDRESS CITY STATE ZIP CODE

I hereby authorize _____insurance company to pay by check made out and mailed to DYNAMIC AQUATIC & PHYSICAL THERAPY, INC., *6718 Andasol Avenue Lake Balboa, CA 91406* for medical and therapeutic expenses due me under this policy. I understand that this may not represent the full payment and I will be responsible for the balance due. I authorize the release of necessary information from my medical records to insurance carriers. A photostatic copy of this assignment and authorization is a s valid as the original.

SIGNATURE: _____ DATE: _____/_____/_____

DYNAMIC Physical Therapy

PATIENT MEDICAL HISTORY FORM

PATIENT'S NAME: _____ DATE OF INJURY: _____

Please mark "X" next to each box if the answer is "YES" and leave blank if answer is "NO"

____PREGNANT	____DIABETES	____HIGH/LOW BLOOD PRESSURE
____HEART PROBLEMS	____ASTHMA	____DIZZINESS/FAINTING
____URINARY INFECTIONS	____H.I.V./A.I.D.S.	____ALLERGIES TO LATEX OR TAPE
____OPEN SKIN WOUNDS	____MALIGNANCIES	____CONTAGIOUS RASH

Please list other health complications and/or surgeries not listed above: _____

_____

Describe how you were injured: _____

_____

_____

_____

On a scale of 1 to 10, how do you rate your pain? _____

What activities make your pain worse? _____

What activities make your pain better? _____

Are you currently taking any medications on a regular basis? Yes_____ No_____

Please list them: _____

What form(s) of treatment or therapy have you previously received (past or present)?_____

_____

What are you prevented from doing since your injury? _____

_____

What is your primary complaint? _____

Did you have an MRI, X-Ray, etc? _____

Does your pain spread to other areas of your body? _____

Do you experience numbness/tingling? _____

Are you able to sleep well? _____

Do you wake up with pain and/or stiffness? _____

Are you experiencing: nervousness, anxiety, tension, and/ or headaches? _____

Patient's Signature _____ Date _____