

Northside Physical Therapy & Sports Rehabilitation Center

Patient information sheet - Please print

[Initial contact date: _____ Prior patient Y N New? Diff? Empl _____ Eval date/time _____ PT: _____ Last MD visit _____ tv? _____]

Name: Last	First	MI	Birthdate: Age:	Soc. Sec.#
Home address		City		Zip
Mailing address		Email:		M F Marital status S M D W
Home phone	Work #	Cell #	Nickname	
Patient's employer		Work address		
Patient job title		Spouse name:	Spouse work#:	
Referring MD		Primary Care MD		NPI
MD DO PA ARNP NPI				
Dx/condition being treated:		Surgery date:	Date of injury/onset:	
Instructions from doctor's Rx		ICD9	Injury from: <input type="checkbox"/> Job <input type="checkbox"/> Auto <input type="checkbox"/> Other:	
# visits auth'd or referred:	Date auth exp:	Have you had Home Health Treatment? Y N		
Billing information				
Primary Insurance Co:		ID#:	Group	
Address:		Phone#:	Subscriber: Birthdate	
Auth #				
Secondary Insurance Co:		ID#:	Group	
Address:		Phone#:	Subscriber: Birthdate:	
Job injury: Employer at time of injury (Circle one:) State L&I Self Insured Print Carrier & phone#:				
Auto accident - please complete Motor Vehicle Accident form. If applicable include below: <u>Attorney</u> name/address/phone:				
Emergency contact name/relationship - (person not at your residence)		Address:	Day phone:	
			Cell phone:	
Key medical history: Please fully complete Patient Medical Questionnaire form, both sides, so we can better understand your medical history.				
Privacy: Northside Physical Therapy is committed to protecting your privacy; no personal or medical information will be released without your consent. Please see and sign our privacy agreement.				

I certify that this information, and that on the Patient Medical Questionnaire, is correct to the best of my knowledge. I consent to treatment at Northside Physical Therapy.

Date: _____ Patient (or guarantor/parent) signature: _____
(if minor, parent or guardian needs to sign and print name below)

Guarantor /Parent/ Guardian PRINT name please _____ Date: _____

Completed by _____ date: _____

NORTHSIDE PHYSICAL THERAPY & SPORTS REHABILITATION
Patient Medical Questionnaire

Name _____ Date _____ Age _____ Birthdate _____ Ht _____' _____" Wt. _____ Dr: _____

Occupation: _____ Are you working now? Yes No. Rt Left handed

1a. **Date** of injury or onset of problem: _____

1b. What is the **primary** problem?

8. Live with others alone Stairs? Y N Rail? Y N

9. When is the pain **better** or decreased? (Check all applicable boxes)

2a. **How did pain start** (Check all applicable boxes)

- Suddenly Injured at work
- Gradually Auto Accident
- Lifting No apparent cause
- Pulling Fall
- Twisting Surgery

Additional Explanation:

- Lying down Pain pills
- Sitting Manipulation
- Standing Injections for pain
- Walking Muscle relaxant pills
- Heat Aspirin/anti-inflammatory pills
- Cold Massage
- Exercises Mornings
- End of day Sleeping//Night
- Movement Other:
- Absolutely nothing changes the pain

2b. Since the onset, has your problem gotten:

- Worse Better Stayed the same

3. What **other types of doctors or health care providers** have you seen for this condition?

- Chiropractor Massage Therapist Physical therapist
- Neurologist/Neurosurgeon Orthopedic surgeon
- Physiatrist Counselor/psychologist Other:

4a. Have you ever had a **similar problem** in the past?

- No Yes: please describe:

10. When is the pain **worse** or increased? (Check all applicable boxes):

- Lying down Sitting
- Walking Standing
- Massage Manipulation
- Exercise Heat
- Cold Mornings
- End of day Sleeping//Night
- Movement Stairs
- Other: Cough/sneeze/deep breath

4b. Do you **smoke** cigarettes? No Yes: _____ PPD

4c. Lost _____ or gained _____ any **weight** recently? No Yes

4d. Have you had any **bowel/bladder** problems? No Yes

4e. Do have problems with any **other joints**? No Yes

List:

11. Pain description (Check all applicable boxes)

- Sharp Burning Cramping Dull
- Shooting Achy Throbbing Other:

4f. How would you describe **your general health**: _____

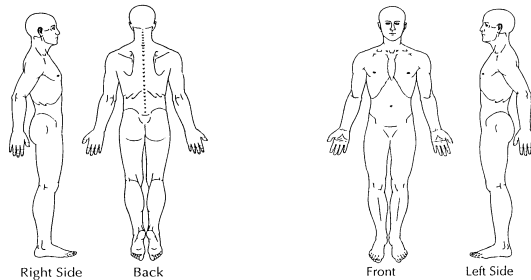
4g. Please list any **surgeries** and dates:

5. **Prior to this onset** were you free of symptoms?

- Yes No

6. Please list all **current medications** (or provide us separate list):

Using the diagrams below, **mark areas of pain and/or numbness**



PAIN SCALE If zero (0) = no pain, and ten (10) = excruciating pain, **what is the intensity of your pain?**

Current pain _____ Best pain _____ Worst pain _____

Have you experienced dizziness? ___ yes ___ no

Have you experienced numbness? ___ yes ___ no

*** *Please continue on other side!!!* →

6b: **Allergies**: _____

7. Check all **diagnostic studies** you have had:

- X-rays Myelogram CT MRI
- EMG Arthrogram Injections
- Bone Density Blood/urine tests Bone scan
- Other _____

Other Medical/ surgical history: Check if you have ever had: Arthritis Blood disorders Broken bones/fractures Cancer Circulation problems Depression Developmental or growth problems Diabetes Head injury Heart problems Hypoglycemia Infectious disease Kidney problems Lung problems MS Muscular dystrophy Osteoporosis Pacemaker Parkinsons Repeated infections Seizures/epilepsy Skin diseases Stroke Thyroid problems Ulcers/stomach problems Other:

Other symptoms: In the past year, have you had any of the following symptoms: Bowel problems (constipation/urgency) Chest pain Coordination problems Cough Difficulty walking Difficulty sleeping Difficulty swallowing Dizziness or blackouts Facial numbness Fatigue Fever/chills/sweats Headaches Hearing problems Heart palpitations Hoarseness Joint pain or swelling Loss of appetite Loss of balance Menstrual problems Nausea/vomiting Pain at night Pelvic/ sexual pain Shortness of breath Urinary problems (leaking, urgency, high frequency) Vision problems Weakness in arms or legs Weight loss/gain Other:
Currently pregnant? __yes __no

We need to understand how your injury, pain, or problem affects what you do in your everyday life.

8a. Check the activities that are **difficult, limited or changed by your current injury or problem**:

- Bending
- Carrying
- Dressing (socks, shirt, pants)
- Driving
- Grooming (shaving, brush teeth/ hair)
- Household chores
- Kneeling
- Lifting
- Moving sit to stand
- Reaching
- Rolling over
- Sleeping
- Sitting
- Sports (regular)
- Stairs
- Standing
- Walking one block
- Walking one mile
- Work duties (regular)

8b. How long can you do the following without changing positions?

Sit _____(minutes / hours) Stand _____(minutes / hours) Walk _____(minutes/ hours)

9. List three activities or tasks that you want physical therapy to help you improve the most? (Please try to be specific-- eg, drive more than 15 minutes, walk an hour, vacuum the entire house, etc.)??

- (1) _____
- (2) _____
- (3) _____

10. **Self assessment of health:** If 100% is how well you felt before the onset of this problem, what percent would you rate yourself now? _____%

11. **Hobbies/interests** or any other information that would be helpful for us to know:

 Patient signature: _____ Date _____

Northside Physical Therapy Records Request Form

Patient name _____ SSN _____ Birth date _____

Referring Physician _____

Please help us obtain important information about your condition! If you have had **x-rays, MRI, CT scan, a bone scan or surgery**, please fill out this form and return it to us. We will request that the information be faxed to us. If you wish to provide this information to us before you come in to PT, you may call the radiology service or the hospital where the procedure was performed (NOT your doctor), and ask them to fax us the **report**.

Our fax number is 325-0817.

Type of Procedure	Date done (mo/year)	Where done (see below)	Body part
X-rays	_____	_____	_____
MRI	_____	_____	_____
CT scan	_____	_____	_____
Bone Scan	_____	_____	_____
Other	_____	_____	_____
Surgery Report	_____	_____	_____

(Name of Facility)

I authorize release of these records to Northside Physical Therapy (fax 325-0817)

✍ Patient signature _____ **Date:** _____

Identify the location by circling one or more:

Inland Imaging (any location) <i>Centralized</i>	Phone 742-3520	Fax 742-3523	Holy Family Hospital	Phone 482-2131	fax 482-2187
Spokane Radiology (Deaconess Medical Building)	747-1187	747-1180	Deaconess Hospital	473-7421	473-7522
VA Hospital	434-7000	434-7140	Valley Hospital	473-5388	473-5741
FAFB	247-5758	247-5925	Sacred Heart Med Records	474-3075	474-3061
Group Health Admin Ctr GH Riverfront GH South Regal GH Lidgerwood GH Veradale	Phone 838-9100	fax 324-3726	Rockwood Radiology Medical Records	838-2531	459-1339
	324-6464 535-2277 482-4402 922-2625	534-1243 482-5071 922-4001	Physicians Clinic	747-1144	353-0942
Columbia Diagnostic	688-6700	688-6795	Spokane Advanced Imaging (on E Rowan)	482-4300	482-4301
NWOS	344-2663	232-8550			

Date called: _____ Time: _____ By: _____

Please *bring with you*:

- your REFERRAL SLIP from your physician and
- your INSURANCE CARD

On your first visit, extra time is set aside for you and your therapist for a thorough physical therapy evaluation and to initiate treatment. Be prepared to be here for 1 ½ - 2 hours. If you must cancel your first appointment, future appointments may be delayed until a longer appointment time is available.

