FREE BODY SF, LLC

CONFIDENTIAL PATIENT INFORMATION

Name:_____

Address:_____City_____State_____ Zip_____

Primary Phone:_____ Secondary Phone:_____

Email Address:_____

Date of Birth _____ Age_____

Primary Care Physician:_____

Referred by:_____

Work Status: Employed____ Retired_____ Disabled_____ Student_____

Marital Status: Married_____ Single_____ Divorced_____ Widow_____

Primary reason for seeking physical therapy:

_____

_____

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. The practitioners at Free Body SF, LLC do not participate in any HMO/PPO insurance organizations. I understand that Free Body SF, LLC will assist me in making collection from the insurance company by providing an invoice for treatment. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment at the time of service.

Patient's Signature:_____Date:_____

Guardian's Signature Authorizing Care:_____Date:_____

IN CASE OF EMERGENCY PLEASE CONTACT:

Name:_____Phone/Mobile:_____Work:_____

Please list your major complaints in order of severity:

Complaint #1: When did you first notice this condition?_____

Was the onset of symptoms immediate or gradual?_____

Are your symptoms constant or intermittent?_____

Is this condition worsening, improving, or unchanging?_____

Are your symptoms severe, moderate or mild?_____

Is your pain dull, sharp, burning, aching, knife-like, throbbing?_____

Are you experiencing any of the following associated symptoms: Pins & needles, tingling, numbness, muscle twitching? Y/N, If so, please explain:

_____

Please indicate which activities relieve (R) or aggravate (A) your condition:

Sitting _____ Standing _____ Walking _____Supine or Side-lying _____

Pushing_____ Pulling_____ Lifting _____ lbs. Gripping _____, Coughing/Sneezing _____

Bowel movements _____ Mental activities _____ Bright Lights _____, Hot or cold _____

Medications _____ please list:_____

Other:_____

Are you currently receiving any other care/treatments for this condition, ie: chiropractor, acupuncture, etc.?

_____

What are your goals?

1._____

2._____

3._____

Complaint #2: When did you first notice this condition?_____

Was the onset of symptoms immediate or gradual?_____

Are your symptoms constant or intermittent?_____

Is this condition worsening, improving, or unchanging?_____

Are your symptoms severe, moderate or mild?_____

Is your pain dull, sharp, burning, aching, knife-like, throbbing?_____

Are you experiencing any of the following associated symptoms: Pins & needles, tingling, numbness, muscle twitching? Y/N, If so, please explain:

_____

Please indicate which activities relieve (R) or aggravate (A) your condition:

Sitting _____ Standing _____ Walking _____Supine or Side-lying _____

Pushing_____ Pulling_____ Lifting _____ lbs. Gripping _____ Coughing/Sneezing _____

Bowel movements _____ Mental activities _____ Bright Lights _____ Hot or cold _____

Medications _____ please list:_____

Other:_____

Are you currently receiving any other care/treatments for this condition, ie: chiropractor, acupuncture, etc.?

_____

What are your goals?

1._____

2._____

3._____

Complaint #3: When did you first notice this condition?_____

Was the onset of symptoms immediate or gradual?_____

Are your symptoms constant or intermittent?_____

Is this condition worsening, improving, or unchanging?_____

Are your symptoms severe, moderate or mild?_____

Is your pain dull, sharp, burning, aching, knife-like, throbbing?_____

Are you experiencing any of the following associated symptoms: Pins & needles, tingling, numbness, muscle twitching? Y/N, If so, please explain:

_____

Please indicate which activities relieve (R) or aggravate (A) your condition:

Sitting _____ Standing _____ Walking _____Supine or Side-lying _____

Pushing_____ Pulling_____ Lifting _____ lbs. Gripping _____, Coughing/Sneezing _____

Bowel movements _____ Mental activities _____ Bright Lights _____, Hot or cold _____

Medications _____ please list:_____

Other:_____

Are you currently receiving any other care/treatments for this condition, ie: chiropractor, acupuncture, etc.?

_____

What are your goals?

1._____

2._____

3._____

CHECK any of the following conditions you have HAD

CIRCLE anything you HAVE

_____Mental disorders _____Diabetes _____Pneumonia _____Infective Disease

_____Epilepsy _____Anemia _____Tuberculosis _____Fungal Infection

_____Tumors _____Glaucoma _____Hepatitis___ _____Herpes____

_____Alcoholism _____Heart Disease _____Arthritis. _____Drug Addiction

_____Cancer _____Parasites

_____Thyroid Disease _____Autoimmune Disease

NERVOUS SYSTEM

___Depression

___Memory Loss/Confusion

___Dizziness

___Fainting

___Convulsions

___Numbness

___Weakness

___Poor Balance/Coordination

___Twitches/Tremor

___Cold/Tingling Extremities

___Sleeping Difficulties

___Headaches

EENT

___Vision Problems

___Flashing LIghts

___Black Spots

___Blurriness

___Hearing Loss

___Ringing in the Ears

___Swallowing Difficulty

CARDIOVASCULAR

___Chest Pain

___Irregular Heartbeat

___High Blood Pressure

___Shortness of Breath

___Lung Problems/Congestion

___Varicose Veins

___Ankle Swelling

GASTROINTESTINAL

___Digestive Problems

___Abdominal Cramping

___Gas/Bloating After Meals

___Heartburn

___Weight Problems

___Frequent Diarrhea

___Frequent Constipation

GENITO-URINARY

___Bladder Trouble: Urgency, Leaking, Incontinence

___Painful Unrination

MUSCULOSKELETAL

___Jaw Pain

___Difficulty Chewing

___Face Pain

___Neck Pain

___Arm/Elbow Pain

___Wrist/Hand Pain

___Mid-Back Pain

___Low-Back Pain

___Thigh/Knee Pain

___Ankle/Foot Pain

___Difficulty Walking

___Leg/Arm Fatigue

Do you walk with an assistive device? Y/N, If so, what do you use and when?

_____

Have you fallen in the last year? Y/N, If so, please state the number of falls in the last year and approximately when they were and why you fell.

_____

_____

Do you have stairs in your home (including indoors and outdoors)? Y/N, If so, how many stairs are there?_____