

Patient Information
(please print)

Date _____ Phone Number _____

Patient _____
Last First Middle

Mailing Address _____ Street Address _____

City _____ State _____ Zip _____

Sex (circle) M F Birthdate _____ SS# _____

If minor, parents name _____

Patient Employed By _____

Business Address _____ Business Phone _____

Occupation _____

Spouse's Name _____ Employed By _____

Spouse's SS# _____ Business Phone _____

Business Address _____

Who Is Responsible For This Account? _____

Relation To Patient _____ Resp. Party's SS# _____

Do You Have Medical Insurance? (circle) Y N If Yes: _____

Name Of Insurance Company _____

SS# Of Person Covered By Insurance _____

Group# _____ Policy # _____

Is There A Secondary Insurance? (circle) Y N

Is This A Work Related Injury? (circle) Y N If Yes: _____

Date Of Injury _____ Name Of W/C Carrier: _____

**IF ALL INSURANCES ARE NOT PROVIDED AT THE TIME OF INTAKE,
WE WILL NOT GO BACK AND BILL THEM.**

Assignment Of Insurance Benefits

I hereby authorize payment of benefits otherwise payable to me up to the stated charges to the provider(s) of service for all bills included with this statement unless otherwise noted. I understand I am financially responsible for an amount not payable or not covered by the plan.

Subscriber's Signature _____ Date _____

In case of emergency, who should be contacted? _____

Phone number _____

We will bill your insurance company and send you a bill upon receipt of their payment.

If you would prefer to pay after each visit, please let us know.

WE ACCEPT CASH OR CHECK ONLY

ARCTIC PHYSICAL THERAPY SERVICES

Welcome to *Arctic Physical Therapy*! We want to make your time spent in physical therapy as beneficial as possible. Please help us by completing this questionnaire prior to your first appointment. We encourage you to ask questions and give your therapist input throughout your course of treatment.

Name: _____ Date: _____ Age: _____

What is your occupation? _____

Reason for physical therapy treatment: _____

Date of injury/onset of symptoms: _____

Symptoms

Please indicate whether you have experienced any of the following symptoms within the last 7 days and circle the level of severity at the present time:

	None	Moderate	Severe
_____ Pain	1-----2-----3-----4-----5-----6-----7-----8-----9-----10		
_____ Numbness	1-----2-----3-----4-----5-----6-----7-----8-----9-----10		
_____ Tingling	1-----2-----3-----4-----5-----6-----7-----8-----9-----10		
_____ Weakness	1-----2-----3-----4-----5-----6-----7-----8-----9-----10		
_____ Dizziness/Falling	1-----2-----3-----4-----5-----6-----7-----8-----9-----10		
_____ Other: Please Specify _____	1-----2-----3-----4-----5-----6-----7-----8-----9-----10		

Please mark on the figures below any areas of:

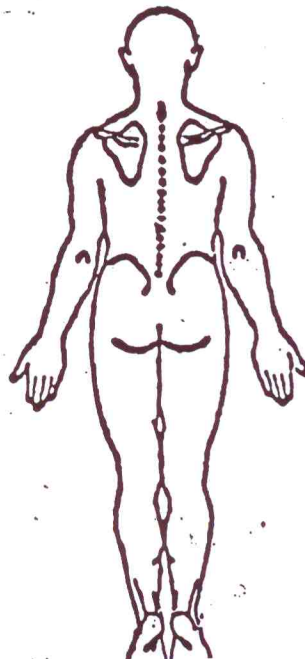
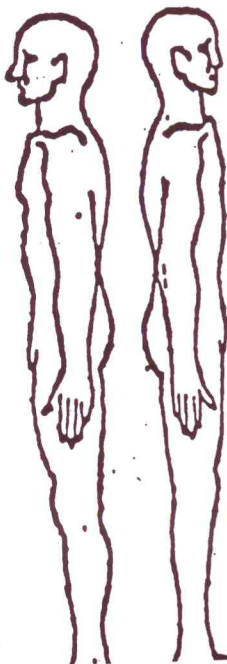
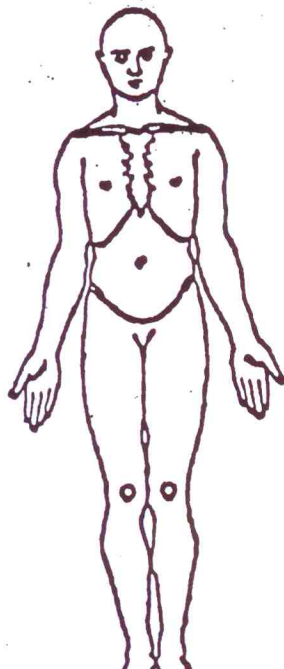
Pain X

Numbness O

Tingling ///

Weakness •

Other symptoms *



Please list all medications you are presently taking and when you last took each. If you don't know the name, indicate what condition the medication is prescribed for:

Medication/Purpose	Last Taken

Allergies: Latex, Adhesives: _____

Surgeries/Dates: _____

Previous Major Illness: _____

Any medical conditions or physical limitations?

Current: _____

Within the last year: _____

List all doctors and other health care providers that you are presently seeing for treatment:

Have you had physical therapy in the past? Yes No Where? _____

If yes, when and for what condition? _____

What are your goals or expectations of physical therapy? (i.e. What would you like to be able to do that you can't do now) _____

What activities are you having difficulty with as a result of this injury or dysfunction? _____