PATIENT INFORMATION FORM

First Name______________________ MI_____ Last____________________ Preferred Name______________________

Date of Birth_____/_____/_____ Age ____Gender_____________________ Patient/Guarantor SS#_____-_____-_____

Email Address____ Martial Status ☐ Single ☐ Married ☐ Other

Street Address____

City_____________________ State__________ Zip Code__________ Profession_________________________________

Primary Phone_________________________ Home/Cell/Work Alternate_______________________ Home/Cell/Work

Emergency Contact Name_________________________ Phone_______________ Relationship_____________________

How did you hear about SSPT? ☐ Friend/Family ☐ Referral ☐ Walk/Drive by ☐ Internet ☐ Other_______________

How would you like to receive courtesy appointment reminders? ☐ E-mail ☐ Phone Call: Cell or Home ☐ Decline

Primary Care Provider___________________________ Referring Provider (if different) ___________________________

Next appointment with Primary Care or Referring Provider (if applicable) ______________________________________

Medical Diagnosis or Primary Concern____

Approximate Date of Onset ______________________________________Date of Surgery_________________________

Is the pain or injury listed above related to a motor Vehicle accident or work accident? ☐YES ☐NO

If yes, choose ☐MOTOR VEHICLE ACCIDENT ☐WORK ACCIDENT Date of Accident _____/_____/_____

PRIMARY INSURANCE OR SELF-PAY

Insurance Company Name ___________________________________ Policy # _________________________________

Policy Holder Name ____ Date of Birth ______________________________

Relationship to Patient _______________________________________ Policy Holder SS# ________-________-_________

Secondary Insurance Name __________________________________ Policy # __________________________________

Please Provide copy of insurance card to front desk.

CONSENT FOR TREATMENT

I, the undersigned, give permission to the practitioner/s of 7 Springs Orthopedics and/or Physical Therapy, to administer evaluation and treatment necessary and advisable for my condition. If patient is a minor, a parent or guardian must sign. **Consent must be signed before we begin treatment.**

____

Signature of Patient (or Legal Guardian) Date

7springs ORTHOPEDICS 7springs PHYSICAL THERAPY

Patient Name____ Date ___________________________________

MEDICAL HISTORY INTAKE FORM

Have you ever been told you have any of the following?

(please check (✓) any that apply)

☐	Asthma or other breathing issues	☐	Arthritis	☐	Anxiety
☐	Cancer	☐	Cancer	☐	Depression
☐	Cirrhosis/Liver Disease	☐	Multiple Sclerosis	☐	Circulation Problems
☐	Diabetes	☐	High Blood Pressure	☐	Epilepsy
☐	Hepatitis	☐	Heart Problems	☐	Stroke
☐	Stomach Ulcers	☐	Tuberculosis	☐	Rheumatoid Arthritis
☐	Kidney Disease	☐	High Cholesterol	☐	Headaches
☐	Hemophilia or Slow Healing	☐	Osteoporosis	☐	Scoliosis
☐	GERD	☐	Gout	☐	Fibromyalgia
☐	Hypo/Hyperthyroidism	☐	Joint Replacement	☐	Sleep Apnea
☐	Angina/Chest Pain	☐	Weakness	☐	Breathing Problems
☐	Fatigue	☐	Dizziness/Lightheadedness	☐	Numbness or Tingling
☐	Pregnant	☐	Joint/Muscle Swelling	☐	Other:

Blood Pressure: ________/________ Where Taken and what device____

Please Check (✓) next to any medications you have taken in the last week and indicate if they are prescribed by a Physician.

☐ Aspirin ☐ Anti-inflammatories ☐ Stomach Ulcer Medications

☐ Tylenol ☐ Vitamins/Mineral Supplements ☐ Herbal Remedies

Please indicate the ones prescribed by a physician:

Please list any other Physician prescribed medication you are currently taking (including pills, injections and/or skin patches.) If more than 9, please attach a list and initial below.

☐List Attached Patient initials ___________ Provider initials ___________

1.______________________ 2. ______________________ 3. ______________________

4.______________________ 5. ______________________ 6. ______________________

7.______________________ 8. ______________________ 9. ______________________

ALLERGIES ☐ NO KNOWN ALLERGIES ☐ LATEX ALLERGY ☐OTHER____________________

☐MEDICATION ALLERGIES ____

____

7springs ORTHOPEDICS

7springs PHYSICAL THERAPY

Patient Name____ Date ________________________________

Use the following scales to **rate your average symptom level** *(circle the appropriate level for each body part).*

"0" = No Symptom, "10" = Makes you pass out the pain is so bad

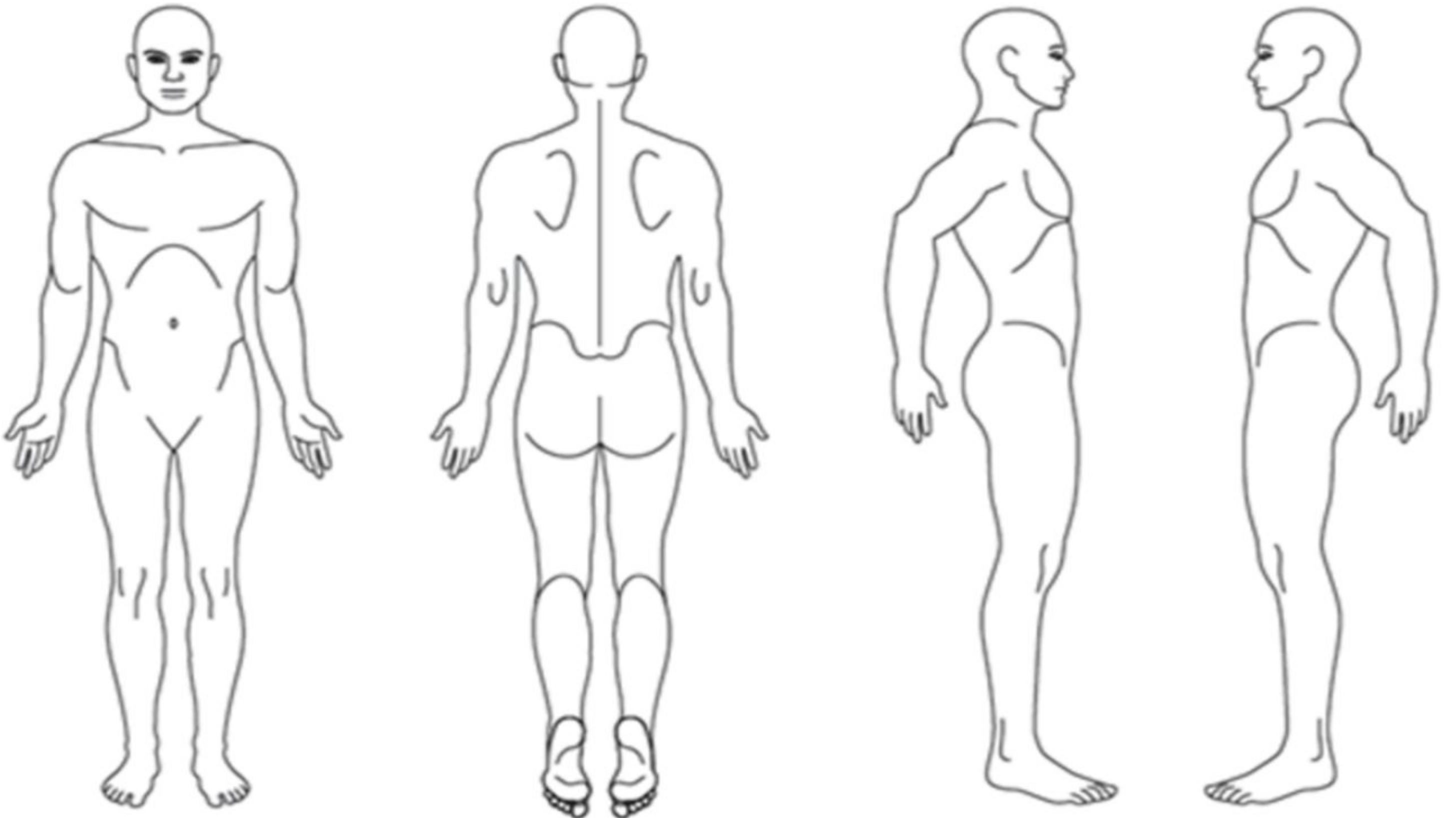
Back: 0 1 2 3 4 5 6 7 8 9 10	**Arm:** 0 1 2 3 4 5 6 7 8 9 10	**Leg:** 0 1 2 3 4 5 6 7 8 9 10
Neck: 0 1 2 3 4 5 6 7 8 9 10	**Shoulder:** 0 1 2 3 4 5 6 7 8 9 10	**Other:** 0 1 2 3 4 5 6 7 8 9 10 **List**______________________________

INSTRUCTIONS

Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. ***Do not indicate areas of pain, which are not related to your present injury or condition.***

Key

(/// Stabbing) (XXX **Burning) (**000 **Pins and Needles) (**= = = **Numbness)**



7springs ORTHOPEDICS | 7springs PHYSICAL THERAPY

Patient Name____ Date ______________________________

Have you **fallen** in the year? ☐ Yes ☐ No If yes, how many times: ____________

If yes to falling, did you **sustain an injury** as a result of the fall? ☐ Yes ☐ No

What was the injury? ____

Do you experience **frequent episodes** of the following (check all that apply)?

☐ Headaches ☐ Dizziness ☐ Nausea ☐ Ear Ringing ☐ Balance Control

Have you noticed a change in your bowel or bladder frequency or control? ☐ Yes ☐ No

If yes, please explain: ____

When did your **current symptoms begin?** (Date)_____/_____/_____ or (Time period) ___________________

Have you experienced these **symptoms before** (please explain below)? ________________________________

____

____

How did your **injury occur,** or **symptoms begin** *(check (✓) all that apply)*? ☐ Accident – work related

☐Accident – Motor Vehicle (Attorney)____________________ Phone Number _____________________

☐ Bending ☐ Reaching ☐ Lifting ☐ Gradual onset ☐ Falling

☐ Accident – Third party/Liability ☐ No Apparent Reason ☐ Dressing

☐ Other: ____

Indicate daily **activities you are having trouble with** due to this injury or onset of symptoms *(check (✓) all that apply)*?

☐ Sitting _______ minutes ☐ Rising ☐ Rising ☐ Lying ☐ Grooming ☐ Turning

☐ Standing _______ minutes ☐Dressing ☐ Bending ☐ Driving ☐ Reaching ☐ Athletics

☐ Walking ________ minutes ☐ Stairs ☐Housework ☐ Other: _____________________________

What **Treatment & Testing** have you received *(check (✓) all that apply)*?

☐ Physical Therapy ☐ Occupational Therapy ☐ Bracing ☐ Injection ☐ Medication

☐ Orthotics ☐ Myelogram ☐ Chiropractic ☐ CT Scan ☐ MRI

☐ Nerve Conduction ☐ X-ray ☐ Other: ____

ACKNOWLEDGEMENT OF DIRECT ACCESS SERVICES

I, _________________________________, acknowledge that I am seeking treatment at **7 Springs Physical Therapy**, without a prescription for Physical Therapy.

Please elect one of the following by placing your initials in the appropriate blank:

______ I acknowledge that I DO NOT have a licensed Doctor of Medicine, Chiropractor, Dentist, Podiatrist, or Doctor of Osteopathic Medicine treating me for the injury for which I am seeking treatment from **7 Springs Physical Therapy**;

______ I am electing direct access to Physical Therapy services and choose **NOT** to have a licensed Doctor of Medicine, Chiropractor, Dentist, Podiatrist, or Doctor of Osteopathic Medicine informed of the initiation of Physical Therapy treatment;

______ I am electing direct access to Physical Therapy services and choose to have the **following** medical professional informed of the initiation of Physical Therapy;

____
Medical Professional's Name

____
Address

____
Today's Date