OC PHYSICAL THERAPY CLINIC

Patient Information

Welcome to **OC Physical Therapy**. Please fill out the information found below to the best of your ability. Please answer these health-related questions to help us design the ideal experience for you. All information will remain confidential.

Patient Name Last_____**First**_____**MI**_____**HT**_____**WT**_____

Mailing Address: _____

City: _____**State/Country:** _____**Zip Code:** _____

Telephone: Home_____**Work:** _____**Cell:** _____

Email Address: _____**DOB:** _____**Sex:** ◯**Female** ◯**Male**

Occupation: _____ **Employer:** _____**Employer Phone:** _____

Emergency Contact: _____ **Phone:** _____

How did you hear about our medical group: ☐**Friend/Family Member** ☐**Physicians** ☐**Other**
Payment for Services will be by:
☐Cash ☐Check ☐Credit Card ☐Health Insurance ☐Automobile Insurance ☐Workers Compensation.
Name of insurance Company: _____**ID #**_____
Secondary Insurance Company: _____**ID#**_____
MEDICAL/FAMILY HISTORY: PLEASE INDICATE WHICH CONDITIONS HAVE BEEN EXPERIENCED BY MARKING APPROPRIATE BOXES).

YES	NO		YES	NO		YES	NO	
◯	◯	**AIDS**	◯	◯	**DISLOCATED JOINTS**	◯	◯	**NECK PAIN**
◯	◯	**ANEMIA**	◯	◯	**EPILEPSY**	◯	◯	**NERVOUSNESS**
◯	◯	**ARTHRITIS**	◯	◯	**GERMAN MEASLES**	◯	◯	**NUMBNESS**
◯	◯	**ASTHMA**	◯	◯	**HEADACHES**	◯	◯	**POLIO**
◯	◯	**BACK PAIN**	◯	◯	**HEART TROUBLE**	◯	◯	**POOR CIRCULATION**
◯	◯	**BLADDER TROUBLE**	◯	◯	**HEPATITIS**	◯	◯	**REPRODUCTIVE DISORDERS**
◯	◯	**BONE FRACTURE**	◯	◯	**HIGH BLOOD PRESSURE**	◯	◯	**RHEUMATISM**
◯	◯	**CANCER**	◯	◯	**HIV**	◯	◯	**RHEUMATIC FEVER**
◯	◯	**CHEST PAIN**	◯	◯	**KIDNEY DISORDER**	◯	◯	**SCARLET FEVER**
◯	◯	**CONCUSSION**	◯	◯	**BOWEL CONTROL LOSS**	◯	◯	**SERIOUS INJURY**
◯	◯	**CONVULSIONS**	◯	◯	**MENSTRUAL CRAMPS**	◯	◯	**SINUS TROUBLE**
◯	◯	**DIABETES**	◯	◯	**MULTIPLE SCLEROSIS**	◯	◯	**TUBERCULOSIS**
◯	◯	**INDIGESTION**	◯	◯	**MUSCULAR DYSTROPHY**	◯	◯	**VENEREAL DX**

Have you been treated by a physician for any health condition in the last year? ◯ Yes ◯ No
Describe Condition: _____ Date of Last Physical Exam: _____

Primary Medical Doctor's Name: _____ Phone: _____
SURGICAL HISTORY:1._____ DATE: _____
2._____ DATE: _____
3._____ DATE:_____

Have you ever had a metal implant? ◯ Yes ◯ No Any other implants:_____
ACCIDENT HISTORY: ☐ JOB ☐ AUTO ☐ OTHER 1_____ Date: _____
☐ JOB ☐ AUTO ☐ OTHER 2 _____ Date: _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Rate Your Symptoms (1-10, 1 being least serious)

1. _____
2. _____
3. _____

SYMPTOMS ARE WORSE IN ☐ MORNING ☐ AFTERNOON ☐ NIGHT

WHEN AND HOW OCCURRED? _____

SYMPTOMS DEVELOPED FROM: ☐ JOB RELATED INJURY ☐ AUTO ACCIDENT ☐ ACCIDENT ☐ OTHER ☐ ILLNESS ☐ UNKNOWN CAUSE ☐ GRADUAL ONSET DATE OCCURRED: _____

SYMPTOMS HAVE PERSISTED FOR #_____HOUR(S) _____DAY(S) _____WEEKS(S) _____MONTH(S) _____YEAR(S)

SYMPTOMS/COMPLAINTS: ◯ COME & GO ◯ CONSTANT

HAVE YOU EVER HAD THIS BEFORE: ◯ NO ◯ YES WHEN? _____

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS? _____

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ◯ YES ◯ NO WHAT KIND?_____
ARE YOU TAKING ANY MEDICATIONS ◯ YES ◯ NO WHAT KIND? _____
ARE YOU PREGNANT ◯ YES ◯ NO DATE of LAST MENSTRUAL PERIOD (ONSET)_____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

☐ BENDING ☐ REACHING ☐ STRAINING AT STOOL ☐ COUGHING ☐ SITTING ☐ TURNING HEAD
☐ LIFTING ☐ SNEEZING ☐ WALKING ☐ LYING DOWN ☐ STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

☐ BENDING ☐ SITTING ☐ LIFTING ☐ STANDING ☐ LYING DOWN ☐ TURNING HEAD ☐ REACHING ☐ WALKING

AUTHORIZATION:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize **OC Physical Therapy Clinic** to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature: (parent if a minor) _____ Date:_____