MEDFORD SPORTS INJURY & THERAPY CENTER

Please use **BLACK** ink only

PATIENT INFORMATION

Name:______________________________ Date: __________
LAST MI FIRST

Address: ______________________________
STREET CITY STATE ZIP

Phone:__________ Date of Birth:________ SS #: __________ Email__________
INCLUDE AREA CODE

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated Age:______ Drivers License__________

Date of onset:__________ ☐ Accident ☐ Illness ☐ Other Gender: ☐ Male ☐ Female

Occupation:__________ Employer: __________

Employer's Address:______________________________ Work Phone: __________
STREET CITY STATE ZIP

Name of Spouse/Guardian:__________ DOB: __________ SS #:__________

Who is responsible for payment:__________ Phone:__________ Relation:__________

*In the Case of an Emergency, Contact:*__________ Relationship: __________
Home Phone:__________ Work Phone: __________
INCLUDE AREA CODE INCLUDE AREA CODE

Insurance Information:

Referring Physician:__________ Date of next appointment: __________

Primary Care Physician: __________

Primary Health Insurance Company: __________ Insured's Name__________
Please produce insurance card for copying

Secondary Health Insurance Company: __________ Insured's Name__________
Please produce insurance card for copying

IS YOUR CONDITION RELATED TO AN ACCIDENT? YES____ NO____

Attorney's Name and Phone: __________
PHONE (INCLUDE AREA CODE)

IS YOUR INJURY JOB RELATED? YES___ NO___ **If yes, please fill out this section.**

Employer's Compensation Insurance Carrier: __________
PHONE (INCLUDE AREA CODE)

Name of Employer at Time of Accident: __________
PHONE (INCLUDE AREA CODE)

Claim #:__________ Date of Accident:__________ Claim Examiner:__________

IS YOUR INJURY FROM A MOTOR VEHICLE ACCIDENT? YES___ NO___ **If Yes please fill out this section**

Name of your Auto Insurance Carrier (PIP Carrier):__________ Phone: __________
INCLUDE AREA CODE

Claim #:__________ Date of Accident: __________ Adjuster: __________

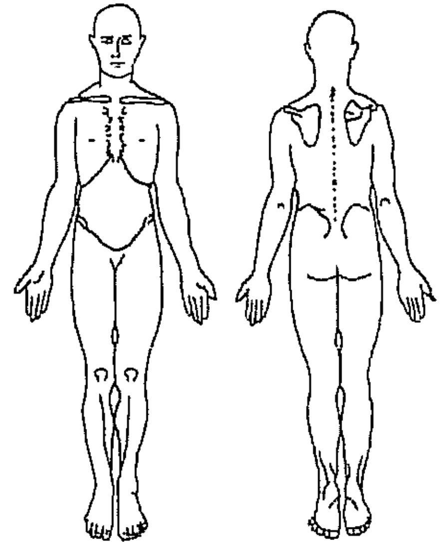
Insured Person is Other Than Yourself: __________

By signing below I recognize that all information that I have provided above is completely true to my knowledge.
I also authorize the above physical therapists to release information in accordance with the separate "Authorization to Disclose Medical Records" signed by me.

____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN

ID produced__________

MEDFORD
SPORTS INJURY &
THERAPY CENTER



Mark your pain or symptoms on the body chart.

What are your symptoms?____

When did you first notice these symptoms and/or when was your surgery if applicable?______________________________

Was the onset of symptoms gradual or sudden?_______________

Which of the following best describes how your injury occurred? (Mark one)

__lifting	__trauma	__incident at work
__car accident	__degenerative process	__unknown
__a fall	__sports/recreation	__other______________________________
__overuse	__running	

Are your symptoms getting: (Mark one) __Better __Worse __Not changing

Have you previously had an injury or surgery to this body part; and when if applicable?____________________________

Describe your pain: (Mark all that apply) __sharp __dull __throbbing __aching __burning __other_______________

Rate your pain on a scale from 0 to 10: (0=no pain, 10=worst possible pain)
at best______ at rest______ at worst______ with activity______

As the day progresses, do your symptoms: (Mark one) __Increase __Decrease __Not change

Does your pain disturb your sleep?_______ While lying still?________ When changing positions?________

Do you have pain and/or stiffness getting out of bed in the morning? ___________________________________

What position do you sleep? (Mark all that apply)
__right side __left side __stomach __back __chair/recliner __other:__________________

Since the onset of your symptoms, have you had? (Mark all that apply)

__Difficulty with control of bowel/bladder function	__Fever/Chills
__Numbness in the genital or anal area	__Numbness
__Malaise (vague feeling of body discomfort)	__Weakness
__Dizziness or fainting attacks	__Problems with vision/hearing
__Unexplained weight change	__Night pain/Sweats
__Any possibility that you could be pregnant	

Name:____ Date:____________
DOB:____________

Name:________________________________Date:____________
DOB:____________

What aggravates your symptoms? (Mark all that apply)

__sitting	__up/down stairs	__reaching overhead	__coughing/sneezing
__standing	__sustained positions	__reaching out from body	__taking a deep breath
__squatting	__repetitive activities	__reaching behind back	__oral activities
__sleeping	__looking up overhead	__reaching across body	__swallowing
__walking	__recreational sports	__any movement	__stress
__rising from sitting	__household activities	__lying down	__other _____________

What relieves you symptoms? (Mark all that apply)

__sitting	__ stretching	__ heat	__wearing splint/orthosis
__standing	__ exercise	__ cold	__alcohol
__lying	__ rest	__ massage	__nothing
__walking	__ medication	__ traction	__other_____________

Previous treatments for this condition:

__none	__ exercise	__ bracing/taping __	__physical therapy	
__medication	__ massage	__injection to spine	__hospitilization	
__ DO/Chiropractor	__ traction	__injection to muscle	__casting	__other________________

Please list any surgeries or other hospitalizations, including the approximate date and reason:

Date	Surgery/Hospitalization	Reason

Please list any injuries for which you have been treated, including the approximate date:

Date	Injury	Date	Injury

Please list any prescription medication you are currently taking (including pills, injections, and/or skin patches):

____

____

Please list any over the counter medications you have taken in the past week:

____

Is there any other information you would like your therapist to know?

____

____

Have you had any of the following tests:

__x-ray __CT Scan __MRI __arthrogram __stress x-ray __bone scan

If so what where the results:____

Have you ever been diagnosed with any of the following conditions? (Mark all that apply)

__Cancer	__Rheumatoid Arthritis	__Allergies
__Heart Problems	__Other Arthritic Condition	__Anorexia/Bulimia
__High Blood Pressure	__Multiple Sclerosis	__Chemical Dependency (alcoholism)
__Stroke	__Thyroid Problems	__Depression
__Diabetes	__Kidney Disease	__Hepatitis
__Asthma	__Emphysema/Bronchitis	__Tuberculosis
__Anemia	__Epilepsy/Seizures	__HIV/AIDS

- If you are a Medicare patient, have you fallen in the last 12 months?_______________
- If you answered yes to the above question, how many falls?__________Was there an injury from the fall?_________