GREAT LAKES PHYSICAL THERAPY

Confidential Medical History/Evaluation

Name: _____ Date: ____/____/____ Referring Dr: _____

Street Address: _____ City: _____ Zip Code: _____

Date of Birth: _____/_____/_____ Phone: _____ SS# _____

Insurance Company: _____ Subscriber ID: _____ Group # _____

Email Address: _____ Married Single or Other:_____

Right or Left Handed: _____Occupation: _____ Is this injury? Work Related Auto Accident **(circle one)**

Chief Complaint: _____ Date of Injury/Surgery: _____

Pain Scale: 0 = no pain; 10 = extreme pain **(circle)** 0 1 2 3 4 5 6 7 8 9 10

Current Symptoms: Pain Numbness Stiffness Weakness **Condition:** Acute Chronic **(circle one)**

List any/all medications you are currently taking: _____

Are you allergic to any medications? _____

List any surgeries: _____

Have you had any Diagnostic or Rehabilitative Services for this injury? MRI X-rays Other: _____

Do you have any of the following?

	YES	NO
Asthma, Bronchits or Emphysema	_____	_____
Shortness of Breath/Chest Pain	_____	_____
Coronary Heart Disease	_____	_____
Do you have a Pacemaker	_____	_____
High Blood Pressure	_____	_____
Heart Attack/Surgery	_____	_____
Stroke/TIA	_____	_____
Blood Clot/Emboli	_____	_____
Epilepsy/Seizures	_____	_____
Thyroid Trouble/Goiter	_____	_____
Anemia	_____	_____
Infectious Disease	_____	_____
Diabetes	_____	_____
Are you pregnant?	_____	_____
Arthritis/Swollen Joints	_____	_____
Osteoporosis	_____	_____
Varicose Veins	_____	_____
Gout	_____	_____
Sleeping Difficulties	_____	_____
Emotional/Psychological Problems	_____	_____
Bowel or Bladder Problems	_____	_____
Severe/Frequent Headaches	_____	_____
Vision/Hearing Difficulties	_____	_____
Dizziness or Fainting	_____	_____

Pain when performing the following activities?

	Mild	Moderate	Severe	Unable
Bending	_____	_____	_____	_____
Carrying Groceries	_____	_____	_____	_____
Change Pos (Sit to Stand)	_____	_____	_____	_____
Climb Stairs	_____	_____	_____	_____
Driving	_____	_____	_____	_____
Extended Computer Use	_____	_____	_____	_____
Household Chores	_____	_____	_____	_____
Kneeling	_____	_____	_____	_____
Lift Children	_____	_____	_____	_____
Lifting	_____	_____	_____	_____
Cancer or Chemo/Radiation	_____	_____	_____	_____
Reading (Concentration)	_____	_____	_____	_____
Self Care – Bathing	_____	_____	_____	_____
Self Care – Dressing	_____	_____	_____	_____
Self Care – Shaving	_____	_____	_____	_____
Sexual Activities	_____	_____	_____	_____
Sleep	_____	_____	_____	_____
Sitting (Prolonged)	_____	_____	_____	_____
Standing (Prolonged)	_____	_____	_____	_____
Walking	_____	_____	_____	_____
Yard Work	_____	_____	_____	_____

Other Medical Conditions _____

Are you aware of your Diagnosis? YES _____ NO _____ Are you aware of your Prognosis? YES _____ NO _____

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Great Lakes Physical Therapy regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Patient/Parent/Guardian Signature: _____ **Date:**_____

I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient/Parent/Guardian Signature: _____ **Date:**_____