Chaparral Physical Therapy Inc.

15555 Main St Ste A-15 Hesperia, Ca 92345 760-244-4288

PATIENTS INFORMATION:

Patient's Name: Date of Birth: Age:

Patient's Social Security: Sex: M / F Date of Injury:

Mailing Address: City:

State: Zip: Contact Number:

Injured Body Part: Referring Dr.:

Person to contact in case of emergency:

Relationship to Patient: Phone:

PRIMARY INSURANCE:

Insurance Company: Policy Number:

Name of Subscriber: Subscriber Date of Birth:

SECONDARY INSURANCE: **Initial here if no secondary insurance:** _____

Insurance Company: Policy Number:

Name of Subscriber: Subscriber Date of Birth:

RESPONSIBLE PARTY: (Name of authorizing party if patient is under 18 years of age)

Name: Relationship to patient: Date of Birth:

ALL PATIENTS: Is your injury the result of a Motor Vehicle Accident? Y / N

MEDICARE PATIENTS: Are you receiving any type of Home Health Care or Visiting Nurses? Y / N

NOTICE OF PRIVACY:

I hereby authorize the use or disclosure of my individually identifiable health information as described in the Privacy Practices disclosure for Chaparral Physical Therapy. A copy of the Notice of Privacy Practices will be provided upon my request.

Signature: **Date:**

Assignment of Benefits - Information Release

I authorize payment of medical benefits to Chaparral Physical Therapy for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize Chaparral Physical Therapy to release to my insurance company or its agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and adminstering claims of benefits.

Signature: **Date:**

Print name of Legal Guardian (If Applicable)

ALL INFORMATION ON THIS FORM IS CONFIDENTIAL

FULL NAME:

Have you had surgery for this injury? Y / N	If yes, how many?
Have you had any of the following medical services (for this injury)?	**Do you now have or have you ever had any of the following?**
Chiropractor Y / N	Asthma/ Bronchitis/ Emphysema Y / N
EMG / NCV Y / N	Shortness of Breath/ Chest pains Y / N
Massage Therapy Y / N	Heart Disease Y / N
Occupational Therapy Y / N	Pace Maker Y / N
Physical Therapy Y / N	High Blood Pressure Y / N
ER Care Y / N	Heart attack/ Heart Surgery Y / N
MRI Y / N	Stroke Y / N
Neurologist Y / N	Blood Clot Y / N
Orthopedist Y / N	Epilepsy/ Seizures Y / N
Podiatrist Y / N	Infectious Diseases Y / N
X-Rays Y / N	Diabetes Y / N
CT Scan Y / N	Arthritis Y / N
	Osteoporosis Y / N
	Sleeping Problems Y / N
	Psychological Problems Y / N
	Headaches Y / N
	Vision/ Hearing Difficulties Y / N
	Numbness/ Tingling Y / N
	Dizziness/ Fainting Y / N
	Bowel/ Bladder Problems Y / N
	Allergies Y / N
	Pins/ Metal Implants Y / N
	Cancer/ Chemo/ Radiation Y / N
	Pregnant Y / N

Current Medications:

_____

_____

_____

_____

_____

INFORMED CONSENT:

I, agree to participate in physical therapy at Chaparral Physical Therapy. I understand that my program may include progressive range of motion, manual techniques, therapeutic exercises, various modalities or other conventional physical therapy techniques.

I understand that it is extremely important that I understand these instructions, and that I should ask any and all questions I may have prior to beginning any treatment.

I understand that there are certain risks while participating in physical therapy that include, but are not limited to, muscle and/or joint soreness, increased pain, bruising, tissue tenderness, blood pressure changes, irregular heartbeat and in very rare cases skin burns, bone fractures, or cardiac arrest.

I understand that every effort will be made to minimize my risk by properly screening me with a preliminary history and evaluation. I should report to the therapist providing my treatment any exercise, modality, or mobilization techniques that causes undo pain that is beyond that which I have experienced in past treatments.

Understanding the risks, and potential benefits, involved in participation in therapy at Chaparral Physical Therapy, I voluntarily choose and consent to participate. I accept and assume the risks involved in doing so.

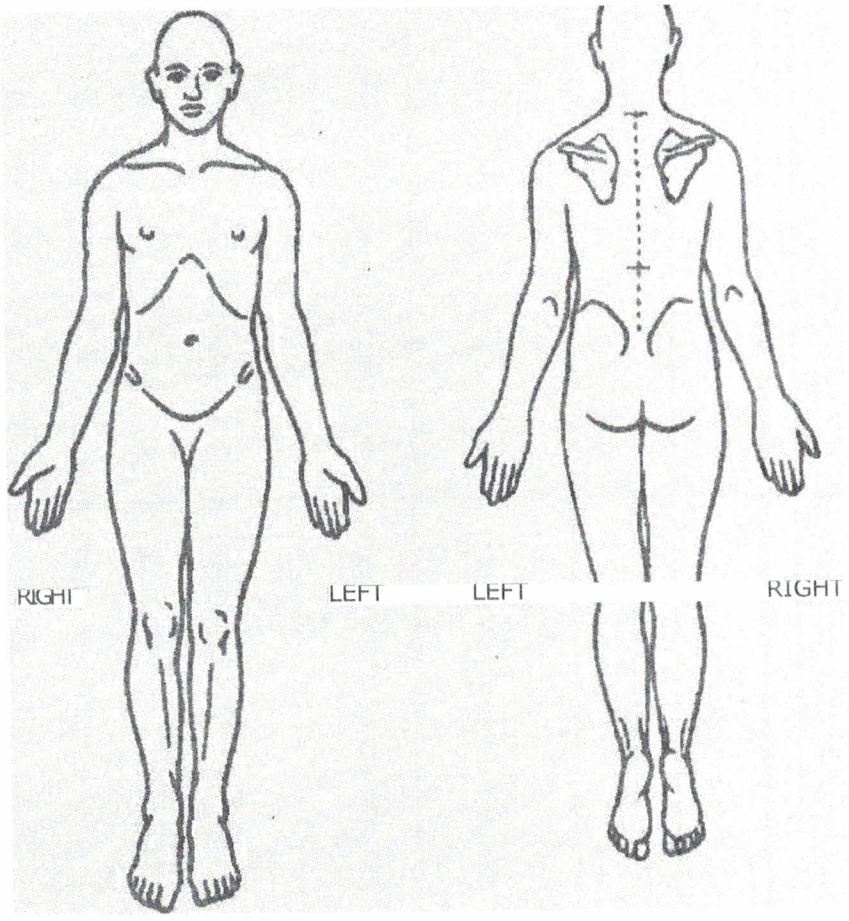
_____ _____

Signature of Patient or Legal Guardian **Date**

ALL INFORMATION ON THIS FORM IS CONFIDENTIAL

Physical Therapy and Sports Center
Chaparral

Graphic Pain Assessment

PAIN INTENSITY SCALE	PAIN LOCATION BODY DIAGRAMS
10 WORST 9 8 VERY SEVERE 7 6 SEVERE 5 4 MODERATE 3 2 1 MILD 0 No Pain	

1. Draw a line on the pain intensity scale at the point that best describes your pain at the present time.
2. Draw the location of your pain on the body diagrams above.
3. If you have any other symptoms, such as tingling or numbness, draw these as a dotted line.

Please describe the details of your injury, including the date of injury and any treatment of the injury: