ActiveCare
Physical Therapy Associates, LLC
900 Rte. 134 Unit 1-2, South Dennis MA 02660
Phone: 508-385-1900 Fax: 508-546-3050

Patient Information:

Mr. ☐ Mrs. ☐ Ms. ☐ ______________________ Single ______ Married ______ Student ____

Mailing Address: ______________________ City/State: ______________________ Zip: ________

Date of Birth: ______________ Home Phone: (____) __________ Cell Phone: (____) ______________

Employer: ______________________________ Phone: (_____) ______________

Address: ______________________ City/State ______________________ Zip: ________

Job Title/Position: ______________________________ Shift: ____________

Is condition related to: Employment ☐ Automobile Accident ☐ *(Please fill out pertinent information below)*

Emergency Contact: Name: ______________________ Relationship: ______________________

Phone number: ______________________________

Person Responsible for Payment:

Name: ______________________________ Phone: (_____) ______________

Mailing Address: ______________________ City/State: ______________________ Zip: ________

Employer: ______________________ Relationship to Patient: ______________________

Referring Physician Name: ______________________ Phone: (_____) ______________

Address: ______________________ City/State: ______________________ Zip: ________

Diagnosis: ______________________ Date of Injury: ______________________

Last MD Appointment: __________ ***Next MD Appointment*** ____________

PCP Name *(if different)*: ______________

Work Related Injury: Please describe below what you are or were doing that caused your injury:

____

____

____

WC Manager: ______________________ **Date of Injury**: ______________________

Name of Workers' Comp Insurance: ______________________ Claim Number: __________

Address: ______________________ City/State: ______________________ Zip: ________

Claims Representative: ______________________ Phone: (_____) ______________

Auto Accident: Please describe below accident leading to your injury: **Date of Accident**: ____________

____

____

Auto Insurance Company: ______________________ Claim Number: ____________

Address: ______________________ City/State: ______________________ Zip: ________

Claims Adjuster: ______________________ Phone: (____) ______________

Primary Medical Insurance:

Insured Person's Name: ____ Phone: (____) ____________________

Relationship to Patient: Self _____ Spouse ____ Parent ____

Insurance: ______________________________ ID #: ______________________ Group #: ______________________

Date of Birth: _______ Employer: ______________________________________

Address: (if different from 1st page) ____________________________________ City/State: ________Zip: _________

Secondary Medical Insurance:

Insured Person's Name: ____ Phone: (____) ____________________

Relationship to Patient: Self _____ Spouse ____ Parent ____

Insurance: ______________________________ ID #: ______________________ Group #: ______________________

Date of Birth: _______ Employer: ______________________________________

Address: (if different from 1st page) ____________________________________ City/State: ________Zip: _________

________________________________**PLEASE SIGN BELOW** ____

Patient's or Guardian's Signature

I authorize the release of any medical or other information necessary to process this claim and I authorize payment of medical benefits to ActiveCare Physical Therapy Associates, LLC for physical therapy services provided to patient.

Signed: ____ Date: ________________________________

ActiveCare
Physical Therapy Associates, LLC
Medical History Form

Name: ______________________________ DOB: ______________________Age:______

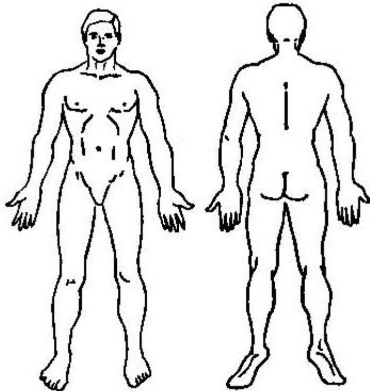
Occupation: ___________________________
Type of work (i.e. lifting, prolonged sitting, standing):_______________________

How and when did the present injury occur? _____________________________________

What are your functional problems with the condition? (What can't you do)? __________

Please indicate with an "x" on the diagram precisely where your pain started.

Using arrows on the diagram please indicate if your pain has spread.



What activities make your symptoms worse?
____
What, if anything, eases your symptoms?
____
What is the effect of coughing?
____
Do your symptoms throb____, twinge _____,
Burn_____, give you numbness/tingling ____.

On a scale of 0-10 (10 being excruciating) how painful was it when it started?
(please circle) 0 1 2 3 4 5 6 7 8 9 10
When it is at its worst? 0 1 2 3 4 5 6 7 8 9 10
When it is at its best? 0 1 2 3 4 5 6 7 8 9 10
How is it today? 0 1 2 3 4 5 6 7 8 9 10

Can you get comfortable at night? Yes____ No _____
How do you feel on arising in the morning? Stiff_____ Sore______ Fine______
Once you start moving, do your symptoms: Worsen____ Ease____ Stay the same______
Have you had anything similar before? Yes_____ No______
Are the symptoms increasing in frequency? Yes_____ No_____
Increasing in severity? Yes_____ No _____
Changing in character? Yes_____ No _____
If yes, please describe ____
Have you been admitted to the hospital or undergone any surgical procedures during the past 5 years?
Yes___ No ___
What was the condition? ____
Is this condition the reason you were referred to Physical Therapy? Yes___ No___
Have you received any Physical Therapy treatments during the past 5 years? Yes___ No___
What was the treatment? ____

Do you think it was helpful in improving your symptoms? Yes_____ No _____
Have you had any **other** previous medical problems or surgeries? Yes_____ No _____
If yes, please specify and provide approximate dates:

____

Have you received any special tests while in the hospital or as an out-patient?
(i.e. CAT Scan, EMG, MRI, X-ray, EKG) Yes ____ No ____
If yes, please specify: ____
Where can the report be located? _____________________________________

Circle YES or NO…

Have you or any immediate family member ever been told you have:.......

	Self	**Family**
Cancer ?	Yes ... No	Yes ..... No
Diabetes ?	Yes .. No	Yes ..... No
High blood pressure ?	Yes .. No	Yes ..... No
Heart disease ?	Yes ... No	Yes ..... No
Angina/chest pain ?	Yes ... No	Yes ..... No
Stroke ?	Yes ... No	Yes ..... No
Osteoporosis ?	Yes .. No	Yes ..... No
Osteoarthritis ?	Yes ... No	Yes ..... No
Rheumatoid arthritis ?	Yes ... No	Yes ..... No

In the past 3 months have you had or do you experience:

A change in your health ?................. Yes..... No
Nausea/Vomiting ?............................ Yes..... No
Fever/chills/sweats ? .... Yes..... No
Unexplained weight change ?............ Yes..... No
Numbness or tingling ?...................... Yes..... No
Changes in appetite ?......................... Yes..... No
Difficulty swallowing ?..................... Yes..... No
Changes in bowel or bladder function ? .... Yes..... No
Shortness of breath ? .... Yes .... No
Dizziness ?.. Yes..... No
Upper respiratory infection ?............ Yes..... No
Urinary tract infection ? .... Yes..... No

Circle YES or NO…

Do you have a history of:

Allergies/Asthma ?.................. Yes .... No
Headaches ? .... Yes .... No
Bronchitis ? .... Yes .... No
Kidney disease ? .... Yes .... No
Rheumatic fever ? .... Yes .... No
Ulcers ? .... Yes .... No
Sexually transmitted disease ? . Yes .... No
Seizures ? .... Yes .... No

Are you currently:

Pregnant ?................................ Yes .... No
Depressed ? .... Yes .... No
Under Stress ? .... Yes .... No

Check all that apply…

Do you have a problem with ... (check all that apply)

☐ Hearing ☐ Vision
☐ Speech ☐ Communication

Do you or have you in the past smoked tobacco?
YES NO
If yes, ________Packs **X** __________Years.
Last tobacco use ____________

Do you drink alcoholic beverages? YES NO
If yes, how many drinks do you routinely have per week? _________/week

Please list ALL medications, dosage and purpose:

____________________________________ ____________________________________
____________________________________ ____________________________________
____________________________________ ____________________________________

What do you hope to achieve in Physical Therapy?

____

The purpose of this questionnaire is to assist us in providing you quality care by obtaining a better understanding of your total health status. Your therapist will answer any questions you may have during your examination. This questionnaire is considered part of your confidential medical record.

____________________________________ ________________
Signature Date