PHYSICAL THERAPY AND CHIROPRACTIC ASSOCIATES OF SOUTH FLORIDA

Welcome to our clinic **Please Print** **Date:**_____

Patient:_____
Last First Middle Initial

Referred by:_____ _____
Patient's email address

Address:_____
Street City State Zip Code

Phone #:_____ Phone #:_____
Home Work/Cell

Soc. Sec. #:_____ Birth Date:_____

Occupation:_____ Employer:_____
(prior occupation if retired)

Employer Address:_____
Street City State Zip

Sex:__F___M Marital Status:__S__M__D__W Spouse/Partner's name:_____
Are you currently working?_____Exercising?_____

Primary Care Physician:_____Phone #_____
Address:_____
Street City State Zip

INSURANCE INFORMATION (and copy of card)

Primary Insurance ID#_____Group #:_____
Name of insured:_____Date of Birth:_____
Insured's Address:_____
Street City State Zip
Insured's Social Security #:_____Occupation:_____
Insured's Employer:_____Work Phone #:_____
Insured's Employer Address:_____
Street City State Zip
Relationship to Patient:_____ Insurance Company:_____
Insurance Address:_____
Street City State Zip

Secondary Insurance ID#_____Group #:_____
Name of insured:_____Date of Birth:_____
Insured's Address:_____
Street City State Zip
Insured's Social Security #:_____Occupation:_____
Insured's Employer:_____Work Phone #:_____
Insured's Employer Address:_____
Street City State Zip
Relationship to Patient:_____ Insurance Company:_____
Insurance Address:_____

Name of Nearest Relative Not Living With You:

Name:_____ Phone:_____ Relationship_____

PHYSICAL THERAPY AND CHIROPRACTIC ASSOCIATES OF SOUTH FLORIDA

List all prior injuries for which you received any medical or chiropractic, or physical therapy evaluation or treatment.

1. 3.

2. 4.

List date and reason for any prior hospitalizations.

1. 3. 5.

2. 4. 6.

List your current symptoms or condition(s) for which you are seeking this evaluation and treatment, their exact location(s) and what event caused the condition.

_____

_____

_____

How long have you been having pain?

__ 1 week or less
__ 1-6 weeks
__ > 6 weeks but < 3 months
__ 3 months – 1 year
__ Over 1 year

How many times have you had this problem in the past?

__ Never
__ 1-3 episodes
__ 4 or more episodes

When did you first have these or similar symptoms?

__ Never
__ < 6 months
__ 6 months – 1 year
__ More than 1 year

What activities or movements make your symptoms worse?

_____

What do you do or take to make your symptoms better? (medication, bed-rest, heat, ice)

_____

__

Describe the quality of your discomfort:
Sharp__ Dull__ Throbbing__ Burning__ Tingling__ Numbness__
Other_____

On a scale of one to ten, with ten being the worse, how would you rate your pain level at this time?

__1 __2 __3 __4 __5 __6 __7 __8 __9 __10
(Better) (Worse)

Do you experience any radiating or shooting pain? Yes__ No___

If so, where? _____

What time of day do you feel your discomfort? _____

Motor Vehicle Accident

Is your pain the result of a motor vehicle accident? Yes O

Location of impact?

O Rear end
O Frontal
O Side
O Both front and rear
O Both front and side
O Both side and rear

Job Injury

Is your pain the result of a work related injury? Yes O

Have you filed a workman's compensation claim? O

Disabled from _____
To _____

Personal Injury

Is your pain the result of a personal injury outside of work or a motor vehicle accident? Yes O

Have you filed a legal suit? O

Please write in a number: 1. PRESENTLY HAVE; 2. PREVIOUSLY HAD; 3. RELATED TO ACCIDENT (DATE :_____)

GENERAL
__Allergy
__Chills
__Convulsions
__Dizziness
__Fainting
__Fatigue
__Fever
__Headache
__Sleep loss
__Weight loss
__Nervousness/depression
__Neuralgia
__Numbness
__Sweats
__Tremors

MUSCULOSKELETAL
__Arthritis
__Bursitis
__Foot Trouble
__Hernia
__Low back pain
__Lumbago
__Neck pain/stiffness
__Shoulder blade pain
Pain or numbness in:
__ Shoulders
__ Arms
__ Elbows
__ Hands
__ Hips
__ Legs

CARDIOVASCULAR
__Hardening of arteries
__High blood pressure
__Low blood pressure
__Pain over heart
__Poor circulation
__Rapid heart beat
__Slow heart beat
__Swelling of ankles

RESPIARTORY
__Chest pain
__Chronic cough
__Difficult breathing
__Spitting up blood
__Spitting up phlegm
__Wheezing

EYES,EARS,NOSE,THROAT
__Asthma
__Colds
__Sore throat
__Deafness
__Dental decay
__Earache/noises
__Ear discharge
__Sinus infection
__Enlarged glands
__Enlarged thyroid
__Nose bleeds
__Failing vision
__Far sightedness
__Gum trouble
__Hay fever
__Hoarseness
__Nasal obstruction
__Near sightedness

__ Knees
__ Feet
__Painful tailbone
__Poor posture
__Sciatica
__Spinal curvature

GENITO-URINARY
__Bedwetting
__Blood in urine
__Frequent urination
__Inability to control bladder
__Kidney infection or stones
__Painful urination
__Prostrate trouble
__Pus in urine
__Painful menstruation
__Hot flashes
__Irregular cycle
__Lumps in breasts

GASTROINTESTINAL
__Belching or gas
__Colitis
__Colon trouble
__Constipation
__Diarrhea
__Difficult digestion
__Abdominal distention
__Excessive hunger
__Gall bladder trouble
__Hemorrhoids
__Intestinal worms
__Jaundice
__Liver trouble
__Nausea
__Pain over stomach
__Poor appetite
__Vomiting
__Vomiting blood

Please list any current medications you are taking. _____

_____

Have you had any x-rays, MRI's or CT scans? Date and place:_____

_____

Prior physicians that have evaluated/treated you for this injury?

_____

(name) (date) (specialty) (Recommendation)

_____

(name) (date) (specialty) (Recommendation)

_____

(name) (date) (specialty) (Recommendation)

Have you ever had surgery for this injury?_____

_____

(Type) (Date) (Surgeon)

Was the surgery helpful? _____

What was the date of your last physical exam? _____

Is there any pertinent family medical history you can share us?

_____

_____

PHYSICAL THERAPY AND CHIROPRACTIC ASSOCIATES OF SOUTH FLORIDA

I,_____, herby authorize Dr David Seidner, and/or such associates or assistants as may be selected by him, to treat me by means of the following procedure:

Manipulation and/or Physical Therapy

I consent to the performance of procedures in addition to or different from those now contemplated, whether or not arising from presently unforeseen conditions which the above named doctor or associates or assistants may consider necessary or advisable in the course of the procedure.

For the purpose of advancing medical education, I consent to the admittance of observers to the treatment room.

The nature and purpose of the procedure, possible alternative methods of treatment, the risks involved and the possibility of complications have been fully explained to me. No guarantee or assurance has been given by anyone as to the results that may be obtained.

I HAVE READ THIS CONSENT AND ITS CONTENTS HAVE BEEN FULLY EXPLAINED TO ME. I CERTIFY THAT I UNDERSTAND THE CONTENTS OF THIS CONSENT AND THAT I AM SIGNING IT VOLUNTARILY AS MY OWN ACT AND DEED.

_____ _____
Patient Signature Date Time AM/PM

_____
Witness

If patient is unable to sign, or is a minor, the following is to be completed by an individual legally authorized to consent for the patient:

Patient is a minor_____years of age, or is unable to sign because: _____

_____

_____ _____
Witness Signature of one legally authorized to consent

_____ _____AM/PM _____
Date Time Relationship to Patient
