Mobile Physical Therapy Welcome Packet

720 E. 11 Mile Road
Royal Oak, MI 48076

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MOBILE PHYSICAL THERAPY

PATIENT INFORMATION

Name _____

Address _____

Home Phone _____ Cell Phone _____

Sex **M** ☐ **F** ☐ Birth date _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Employer/School _____ Occupation _____

Employer/School Address _____ Phone _____

Contact In case of Emergency: _____

Phone _____ Relationship _____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy Practices.

X_____

Signature of Patient, or Personal Representative

TREATMENT CONSENT

I hereby give consent to Mobile Physical Therapy, physicians, and or medical affiliates to perform upon myself or my children/dependents all medical treatments and procedures that the physician deems necessary.

X _____

Signature of Patient or Personal Representative

ACCIDENT INFORMATION

Is condition due to an accident? ☐Yes ☐No ☐Unknown

_____

Date of accident _____Type of Accident ☐ Auto ☐Work ☐Home ☐Other _____

Did you report your accident? ☐Yes ☐No

If so, to whom? ☐ Auto Ins. ☐Employer ☐Worker Comp ☐Police ☐Other

PATIENT CONDITION

Reason for Visit

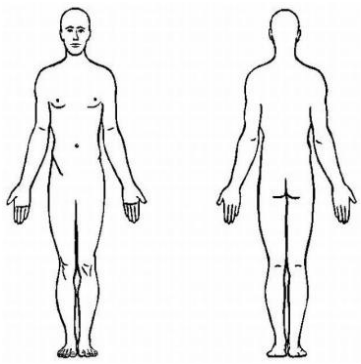
_____

When did your symptoms appear?

_____

Is this condition getting progressively worse? ☐Yes ☐No ☐Unknown

Circle on the picture where you have pain, numbness or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)

_____

Type of Pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbing ☐Aching
☐Burning ☐Tingling ☐Cramping ☐Stiffness ☐Swelling ☐ Shooting

How often do you have this pain? _____

Is the pain constant, or does it come and go? _____

Does pain interfere with your ☐Work ☐Sleep ☐Daily Routine ☐Recreation

Activities or movements that are painful to perform: ☐Sitting ☐Standing ☐Walking
☐Bending ☐Lying Down

Additional Comments: _____

_____

PAST MEDICAL HISTORY

What treatment have you already received for your condition?

☐Medication ☐Surgery ☐Physical Therapy

☐Chiropractic ☐None ☐Other _____

Date of Last: Physical Exam _____ X-Ray _____

MRI, CT or Bone Scan _____ Blood Test _____

Are you pregnant? ☐Yes ☐No Due Date _____

Please list and briefly describe the following:

Falls_____

Head Injuries _____

Broken Bones _____

Dislocations _____

Surgeries _____

Diseases, including Family History_____

CONDITIONS (please check all that apply)

- ☐ AIDS
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruises easily
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disk
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headache
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson ’s disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rash
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sexually Transmitted Disease
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors, Growths
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infection
- ☐ Whooping Cough
- ☐ Other _____
- ☐ Other _____

EXERCISE ***WORK ACTIVITY*** ***HABITS***

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor
- ☐ Smoking
- ☐ Alcohol
- ☐ Coffee/Caffeine Drinks
- ☐ High Stress Levels
- Packs/Day _____
- Drinks/Week _____
- Cups/Day _____
- Reason_____ ___

Please complete the following list:

Medications: _____ Vitamins/Herbs/Minerals:_____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

If you have a medication list, we can copy it for you.

Do you have any allergies? ☐Yes ☐No

_____

If so, please explain: _____

_____