Advanced
PHYSICAL THERAPY CENTERS

Who referred you to Advanced Physical Therapy Centers?
_____

Was this the first time you heard of Advanced Physical Therapy Centers? ☐Y ☐ N. If No, WHERE? _____

Have you previously gone through physical therapy? ☐Y ☐ N
For what _____ Office Location _____

Did you feel your problem was resolved afterwards? ☐Y ☐ N

Appt Date: _____ **Time:** _____

Therapist:_____

PATIENT INFORMATION

Patient Name:

_____
Last First Middle

Date of Birth: _____/_____/_____

Address: _____
Street

_____
City State Zip

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Minor ☐ Widowed ☐ Separated ☐ Divorced

Are you Currently: ☐ Employed ☐ Full Time Student ☐ Disability ☐ Unemployed ☐ Part Time Student ☐ Retired

Patient Employer/School: _____
Occupation: _____
Employer/School Address: _____
_____
Insurance Provider: _____
Responsible Party: _____ **DOB**_____
Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

ACCIDENT INFORMATION

Is this condition due to an accident? ☐ Yes ☐ No
Date of Injury: _____
Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other
Have you made a report of your accident? ☐ Yes ☐ No
Attorney Name:_____
Phone: _____

CONTACT INFORMATION

Home Phone: (____)_____
Cell Phone: (____)_____
Work Phone: (____)_____
E-Mail Address: _____
_____
Best time and place to reach you: _____
_____

IN CASE OF EMERGENCY CONTACT:

Name_____
Relationship: _____
Home Phone: ( ) _____
Cell Phone: (____) _____

REFERRING PHYSICIAN

Name: _____
Phone: _____
Fax: _____
Address: _____

PRIMARY CARE PHYSICIAN

Name: _____
Phone: _____
Fax: _____
Address:_____

PATIENT CONDITION

Reason for Visit:_____
When did your symptoms appear?_____
Is this condition getting progressively worse? ☐ Yes ☐ No ☐ No Change
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain, ER Visit)_____
Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other
How often do you have this pain?_____
Is it constant or does it come and go?_____
Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down