Stracker Physical Therapy, Inc.

(714) 514-5286 | www.strackerpt.com | info@strackerpt.com

Patient Information Form

Full Name: _____ Preferred Nickname: _____

Date of Birth: _____

Preferred Phone: (H/C/W)_____ Alt. Phone: (H/C/W)_____

Email Address: _____

Home Address: _____

City: _____ Zip Code: _____

Treatment Location (if different): _____

City: _____ Zip Code: _____

Responsible Party (if other than patient): _____

Phone: _____

Spouse/Partner/SO: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Referring Physician: _____ Phone: _____

Office Location: _____

Primary Physician: _____ Phone: _____

Office Location: _____

Dentist (if applicable): _____ Phone: _____

How did you hear about us? _____

□ I will be paying by: Cash Check Credit card

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on these forms and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify Stracker Physical Therapy of any changes in my status or the above information.

_____ _____
Signature Date

_____ _____
Parent/Guardian (if minor) Date

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Insurance Carrier Information

(If Applicable)

PRIMARY INSURANCE: _____

Name of Primary Insured: _____

DOB of Primary: _____ Insurance ID#: _____

Group #: _____

Insurance phone #: _____

Relation to Insured: Self / Husband / Wife / Dependent / Other: _____

SECONDARY INSURANCE: _____

Name of Primary Insured: _____

DOB of Primary: _____ Insurance ID#: _____

Group #: _____

Insurance phone #: _____

Relation to Insured: Self / Husband / Wife / Dependent / Other: _____

►NOTICE OF CANCELLATION POLICY

Please be advised of the following policy with regard to cancellations and unavailability:
Cancellations should be made at least 24 hours in advance. **A $45.00 fee applies if cancellation of appointment is within 24 hours of the appointment time. The full treatment fee applies if there is no answer on therapist's arrival**. Exceptions to cancellation apply only to illness and patient/family emergencies. Health care coverage providers will not reimburse these fees.
Please be ready for your scheduled appointment to avoid delays in your therapy session. If we cannot accommodate you within the time allotted, we will have to reschedule or cancel your appointment.

SIGNED: _____ DATE: _____

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Patient Questionnaire

Patient Name: _____ Date: _____

Age: _____ **Handedness** *(Circle one)**: Right Left*** **Sex** *(Circle one)**: Female Male***

Height: _____ Weight: _____

JOB/ACTIVITY STATUS

□ *Part-time Full-time Disability* **WORKER** at _____ with title of _____

□ **HOMEMAKER** □ **RETIRED** □ **STUDENT**

□ Work environment/activities: _____

□ Special work accommodations: _____

□ Recreational activities: _____

INJURY AND FUNCTIONAL STATUS

Type of Injury (Circle one): Work-related Auto accident Chronic Other _____

Primary concern to be addressed (Circle one): Pain Numbness/tingling Dizziness Balance Mobility

Primary area(s) of pain (if applicable): _____

Primary area(s) of numbness/tingling (if applicable): _____

Other concerns to address as able: _____

_____

Date of INJURY or ONSET of symptoms: _____

Describe what you think **caused** the symptoms: _____

_____

_____

Who have you seen for this problem and what have they done for you? (Include phone numbers if known.) _____

_____

_____

Have you had any **Injections** for this problem? (Circle one.): NO YES Type: _____

Describe any **Previous Injuries** you have had: _____

_____

List all **Surgeries** that you have undergone (include dates as able): _____

_____

_____

List all Doctor-recommended **Precautions or Restrictions**: _____

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MEDICAL HISTORY **(Please mark YES (Y) or NO (N) for the following questions/conditions)**

Y/ N		DETAILS
____	**Excessive fatigue of sudden onset**	_____
____	**Sudden shortness of breath**	_____
____	**Pacemaker and/or defibrillator**	_____
____	**Recent swelling or edema**	_____
____	**Pregnant**	_____
____	**Loss/transplant or dysfunction of an organ**	_____
____	**Imaging (X-Rays, CAT scans, MRI's, bone scans)**	_____
____	**Cancer/tumors**	_____
____	**Unexplained weight loss or weight gain**	_____
____	**Incontinence of bladder or bowel**	_____
____	**Do you smoke? How much?**	_____
____	**Recent fevers or night sweats**	_____
____	**History of falls**	_____
____	**History of nausea or dizziness**	_____
____	**Is your general health status poor?**	_____
____	**Do you consider yourself depressed?**	_____
____	**Family history (Cancer, diabetes, heart disease, etc.)**	_____

Do you have irregularities of the following systems?

_____	**Ears, nose, or throat**	_____
_____	**Lungs (asthma, persistent cough, etc.)**	_____
_____	**Heart (high blood pressure, heart attacks, etc.)**	_____
_____	**Circulation (blood clots, poor circulation, etc.)**	_____
____	**Gastrointestinal (ulcers, reflux, etc.)**	_____
____	**Eyes (change in acuity, blurred vision, etc.)**	_____
____	**Genitourinary (kidneys, incontinence, etc.)**	_____
____	**Musculoskeletal (sprains, arthritis, etc.)**	_____
____	**Neuromuscular (weakness, strains, numbness etc.)**	_____
____	**Neurological (stroke, Parkinson's, seizures, etc.)**	_____
____	**Metabolic/endocrine (thyroid, diabetes, etc.)**	_____
____	**Skin (ulcers, rashes, etc.)**	_____
____	**Dental (TMJ, etc.)**	_____

List ALL CURRENT and RECENT MEDICATIONS and SUPPLEMENTS
(Use other included form if Medicare)

Drug Name	**Using Now**	**Benefits/ Side Effects** (if known)
_____	Yes/ No	_____
_____	Yes/ No	_____
_____	Yes/ No	_____
_____	Yes/ No	_____
_____	Yes/ No	_____

(You may continue on the back of this form for additional information)