

# *Agapé Physical Therapy*

## Patient Information Questionnaire

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

### **Patient Registration Information**

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ SS# \_\_\_\_\_

E-mail Address \_\_\_\_\_ (if you are interested in receiving updates from Agape)

In case of emergency whom should we contact? \_\_\_\_\_ Phone \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Primary Doctor \_\_\_\_\_ Phone \_\_\_\_\_

### Primary Insurance Information – Please print clearly

Primary Insurance \_\_\_\_\_ Subscriber ID \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Relation to patient \_\_\_\_\_

Subscribers Address (if different from patient) \_\_\_\_\_

Subscriber's DOB (required) \_\_\_\_\_ Phone # \_\_\_\_\_

\*If your benefits depend on pre-authorization it is your responsibility to inform us\*

### Secondary Insurance Information

Secondary Insurance Name \_\_\_\_\_ Subscriber ID \_\_\_\_\_

Subscribers Name \_\_\_\_\_ Relation to patient \_\_\_\_\_

Subscribers DOB (required) \_\_\_\_\_

### **Injury Description**

What is your main complaint and in what area is it located? \_\_\_\_\_

**When** did the injury occur? Date \_\_\_\_\_

**How** did the injury occur? \_\_\_\_\_

Describe your level of function **before** injury: **Normal** **Restricted**, Please Specify: \_\_\_\_\_

Check any of the following activities which you **currently** have **difficulty** with due to your injury:

<input type="checkbox"/> Housekeeping	<input type="checkbox"/> Lifting	<input type="checkbox"/> Driving	<input type="checkbox"/> Shopping	<input type="checkbox"/> Reaching
<input type="checkbox"/> Dressing	<input type="checkbox"/> Cooking	<input type="checkbox"/> Climbing Stairs	<input type="checkbox"/> Child Care	<input type="checkbox"/> Bending
<input type="checkbox"/> Yard Work	<input type="checkbox"/> Sit to Stand	<input type="checkbox"/> Showering	<input type="checkbox"/> Sleeping	

Other limitations: \_\_\_\_\_

**Rating** – Please rate your pain using a **0 – 10 Scale** (0 = No pain, 10 = The worst pain that you can imagine)

**Worst** pain since onset: \_\_\_\_\_ **Least** pain since onset: \_\_\_\_\_ **Current** pain: \_\_\_\_\_

Are your symptoms getting **worse – better - the same** since your injury? Circle one

What have you been doing to decrease your pain? \_\_\_\_\_

Have you ever had these symptoms before? Yes \_\_\_ No \_\_\_ If so, When? \_\_\_\_\_

Have you had any injections for your injury? Yes \_\_\_ No \_\_\_ If so, When? \_\_\_\_\_

Have you had physical therapy for your injury? Yes \_\_\_ No \_\_\_ If so, When? \_\_\_\_\_

Please **circle** the tests you have had performed for your injury:

None      X Rays      MRI      CT Scan      Bone Scan      Other (Explain) \_\_\_\_\_

Check **all** of those which apply to your **current** condition:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Work Related Injury | <input type="checkbox"/> Sports Injury                      | <input type="checkbox"/> Fall           |
| <input type="checkbox"/> Surgery             | <input type="checkbox"/> Aggravation of Pre-Existing Injury | <input type="checkbox"/> Causes Unknown |
| <input type="checkbox"/> Injury Recurrence   | <input type="checkbox"/> Motor Vehicle Accident             | <input type="checkbox"/> Lifting Injury |
| <input type="checkbox"/> Other: _____        |   |   |

### Medical History

	Yes	No		Yes	No		Yes	No
Diabetes	___	___	Cancer	___	___	Metal Implants	___	___
Chest Pain	___	___	Asthma	___	___	Dizziness	___	___
Heart Disease	___	___	Arthritis	___	___	Fractures	___	___
High Blood Pressure	___	___	Aids/HIV	___	___	Skin Allergies	___	___
Respiratory Problems	___	___	Allergies to Heat	___	___	Nausea/Vomiting	___	___
Kidney Problems	___	___	Allergies to Cold	___	___	Ear Ringing	___	___
Are You Pregnant	___	___	Seizures	___	___	Hypoglycemia	___	___
Bladder Problems	___	___	Headaches	___	___	Pacemaker	___	___
Anemia	___	___	Stroke	___	___	Heart Murmur	___	___
Osteoporosis	___	___	Psychiatric Care	___	___	Congenital Heart Lesions	___	___
Respiratory Disease	___	___						
Artificial Heart Valves	___	___	Other Allergies:	_____				

List any medications you are taking: \_\_\_\_\_  
\_\_\_\_\_

What type of non-work/physical activities/sports are you involved in? \_\_\_\_\_

Is there any other information about your present health that we should know about? \_\_\_\_\_

### Employment Information

Occupation: \_\_\_\_\_

Primary work duties: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone \_\_\_\_\_ ext. \_\_\_\_\_

Are you currently working? Yes No If no, when did you last work? \_\_\_\_\_

If yes, are your work duties? Full Restricted How many hours per week do you work? \_\_\_\_\_

What critical work duties have been most affected by your problem? \_\_\_\_\_

**To the best of my knowledge, the information I have given is complete and true.**

**I hereby give my consent to receive therapy services.**

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

*For therapist use below this line* \_\_\_\_\_

*PT Notes:* \_\_\_\_\_

\_\_\_\_\_

*Therapist Signature:* \_\_\_\_\_ *Date:* \_\_\_\_\_