SPORT CLINIC PT move forward
414.351.5794
www.sportclinicpt.com

**Bayside**
8911 N. Port Washington Rd.
Bayside, WI 53217

**Cedarburg**
7269 State Road 60
Cedarburg, WI53012

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| **PATIENT INFORMATION** | | | **EMAIL ADDRESS:** |
|---|---|---|---|
| First Name: | Last Name: | Middle Initial: | Date: / / |
| Address: | City: | State: | Zip: |
| Birth date: / / | Age: | ☐ Male ☐ Female | S.S. #: - - |
| Home Phone: ( ) - | Alternate Phone (Cell, Pager): ( ) - | | Driver's License: |
| Chose Clinic Because/ Referred to Clinic By ☐ Dr.: | | ☐ Insurance Plan ☐ Family ☐ Friend | |
| ☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other: | | | |

| **WORK INFORMATION** | | |
|---|---|---|
| Employer: | Work Phone ( ) - | Ext. |
| Occupation: | Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed | |

| **CARE PROVIDER INFORMATION** | |
|---|---|
| Referring Dr: | Referring Dr. Phone: ( ) - |
| Regular Dr./PCP | Regular Dr./PCP Phone: ( ) - |

| **INSURANCE INFORMATION** | **( PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST )** |
|---|---|
| Primary Insurance Name: | Date of Accident: |
| Subscriber's Name (If different): | Birth date : / / |
| ID. #: | Group/Policy # |
| Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: | |
| Name of Secondary Insurance: | |
| Subscriber's Name: | Birth date : / / |
| ID. #: | Group/Policy # |
| Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: | |

| **AUTO OR WORK INJURY CLAIM** | **( PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP )** | | |
|---|---|---|---|
| Insurance Name: ☐ Auto : | ☐ Labor & Industries: | | |
| Adjuster/Claim Manager: | Phone: | Ext.: | |
| Address: | City | State: | Zip: |
| Claim #: | Accident Date: / / | Cause: | |

| **ATTORNEY INFORMATION** | | | |
|---|---|---|---|
| Name: | Law Firm: | Phone: ( ) - | |
| Address | City | State: | Zip: |

| **IN CASE OF EMERGENCY** | | |
|---|---|---|
| Name of Local Friend or Relative (Not Living at Same Address): | | |
| Relationship to Patient: | Home Phone: ( ) - | Work Phone: ( ) - |

I authorize my insurance benefits be paid directly to SPORT Clinic Physical Therapy. I understand that I am financially responsible for any balance. I also authorize SPORT Clinic Physical Therapy to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

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# PAST MEDICAL HISTORY FORM

**Patient Name** _____

| BLOOD PRESSURE | YES | NO |
|---|---|---|
| Hypertension | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ |
| Normal Blood Pressure | ☐ | ☐ |

| HEART DISEASE | YES | NO |
|---|---|---|
| Heart Attack | ☐ | ☐ |
| Atherosclerotic Disease | ☐ | ☐ |
| Myocardial Infarction | ☐ | ☐ |
| Rheumatic Heart Disease | ☐ | ☐ |
| Heart Murmur | ☐ | ☐ |
| Do you have a pacemaker | ☐ | ☐ |

| MUSCLE CONDITION | YES | NO |
|---|---|---|
| Next/Back Strain | ☐ | ☐ |
| Muscle Tear | ☐ | ☐ |
| Upper Extremity | ☐ | ☐ |
| Lower Extremity | ☐ | ☐ |
| Plantar Fasciitis | ☐ | ☐ |

| LUNGS | YES | NO |
|---|---|---|
| Asthma | ☐ | ☐ |
| Emphysema | ☐ | ☐ |
| Shortness of Breath | ☐ | ☐ |

| JOINT CONDITIONS | YES | NO |
|---|---|---|
| Back/Neck Arthritis | ☐ | ☐ |
| Disc/Sciatica | ☐ | ☐ |
| Hip/Knee Arthritis | ☐ | ☐ |
| Ankle Sprain | ☐ | ☐ |

| OTHER CONDITIONS | YES | NO |
|---|---|---|
| Muscular Dystrophy | ☐ | ☐ |
| Rheumatoid Arthritis | ☐ | ☐ |
| Multiple Sclerosis | ☐ | ☐ |
| Epilepsy | ☐ | ☐ |
| Gout | ☐ | ☐ |
| Fibromyalgia | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Hearing Loss | ☐ | ☐ |
| Poor Eyesight | ☐ | ☐ |
| Fainting | ☐ | ☐ |
| Cancer (presently or history of) | ☐ | ☐ |

Other: _____

_____

| EXERCISE | WORK ACTIVITY | STRESS LEVEL | HABITS | |
|---|---|---|---|---|
| ☐ None | ☐ Sitting | ☐ Low | ☐ Smoking | Packs a Day ____ |
| ☐ 1-2 x Week | ☐ Standing | ☐ Medium | ☐ Alcohol | Drinks a Week ____ |
| ☐ 3-4 x Week | ☐ Light Labor | ☐ High | ☐ Coffee/Soda | Cups a Week ____ |
| ☐ 5+ x Week | ☐ Heavy Labor | | | |

What types of exercise do you perform? : _____

What things cause stress in your life? :

Are you taking any seizure medication? ☐YES ☐NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐YES ☐NO If yes list name: _____

List all medications you are currently taking or provide a copy of your list: _____

List all surgeries in the past two years (Including dates): _____

Are you pregnant? ☐ YES ☐ NO What week?: _____

Have you had any injuries related to work? ☐ YES ☐ NO If yes list body part and date.: _____

Have you had any Auto Accidents ☐ YES ☐ NO If yes list body part and date.: _____

Have you had Physical Therapy before? ☐ YES ☐ NO Where:

_____ _____

Signature of Patient, Parent, Guardian, Personal Representative Date

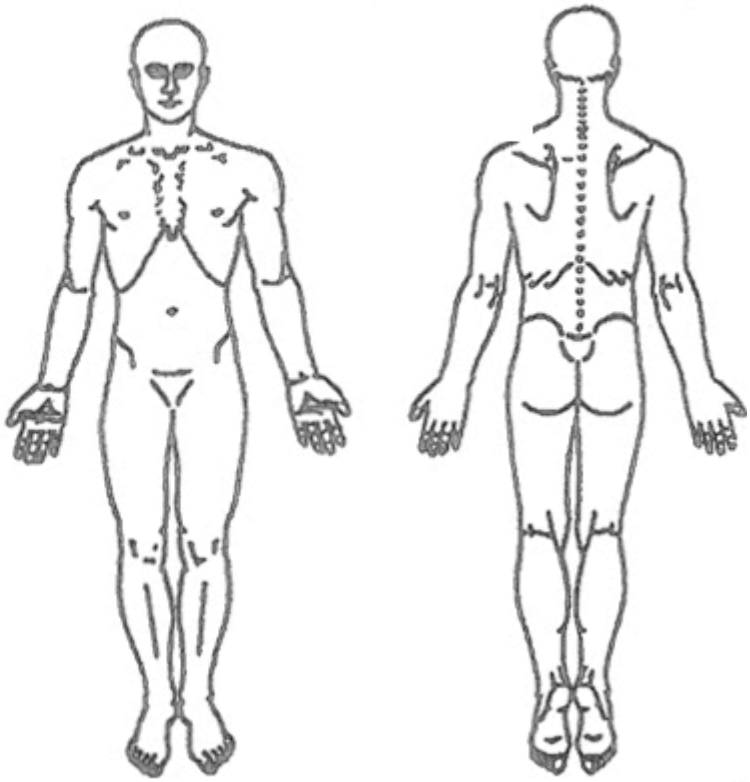
## *Pain and Symptom Status Report*

**Name:** _____ **Date:** _____

**Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing**

| Ache | Burning | Numbness |
|---|---|---|
| MMM | — — — | O O O O |
| M | — — | O O O |

| Pins and Needles | Stabbing | Other |
|---|---|---|
| o o o o o o o o o o | / / / / / / | x x x x |
| o o o o o o o o | / / / / | x x x |



## *Chief Complaint and Visual Analog Scale*

**My Chief Complaint is:** _____
**Date First Symptom of your problem occurred on.** _____

**2nd Complaint** _____

**3rd Complaint:** _____

**Please circle on the scale below to indicate your <u>CURRENT</u> level of pain:**

**No Pain** **0 1 2 3 4 5 6 7 8 9 10** **Pain as bad as it gets.**

**Please circle on the scale below to indicate your <u>AVERAGE</u> level of pain:**

**No Pain** **0 1 2 3 4 5 6 7 8 9 10** **Pain as bad as it gets.**

**Please circle on the scale below to indicate your <u>WORST</u> level of pain:**

**No Pain** **0 1 2 3 4 5 6 7 8 9 10** **Pain as bad as it gets.**

*Additional Comments* _____