PLUMAS Physical Therapy

78 Central Ave. | Quincy, CA 95971
8989 CA - 89 | Blairsden, CA 96103

PHONE: (530) 283-2202 FAX: (530) 283-2204

| PATIENT INFORMATION | | | |
|---|---|---|---|
| Last Name | First Name | | Middle Initial |
| Address | City | State | Zip Code |
| Home Phone | Cell Phone | Email | |
| Date of Birth | SSN | Sex □ M □ F | |
| Height | Weight | | |
| Marital Status □ Single □ Married □ Divorced □ Widowed □ Separated | | | |

| EMPLOYER INFORMATION | |
|---|---|
| Employer Name | Employment Status □ FT □ PT □ Self-Employed □ None □ Retired □ Student |
| Work Phone Number | Occupation |

| PHYSICIAN INFORMATION | |
|---|---|
| Name of Referring Physician | Name of Primary Care Physician |

| EMEGENCY CONTACT INFORMATION | | |
|---|---|---|
| Contact Name | Phone Number | Relationship □ Parent □ Spouse □ Other |

| ADDITIONAL QUESTIONS | | | |
|---|---|---|---|
| Date of Injury / Onset Set | Accident Related □ Yes □ No □ Auto – State? _____ □PI | Work Related □ Yes □ No | Diagnosis / Body Part |
| Post Surgical □ Yes □ No □ Unknown Surgery Date (if applicable) _____ | | Surgery Description | |
| Have you had any prior therapy this year? □ Yes □ No ( PT/OT/SP or Chiropractic) | | How did you hear about us? | |

| HISTORY | | |
|---|---|---|
| Exercise Frequency | Exercise Type | |
| Do you smoke? □ Yes □ No | Have you ever smoked? □ Yes □ No | How often? |
| Are you pregnant? □ Yes □ No | Do you have a pacemaker? □ Yes □ No | |

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| |
|---|
| Allergies? |
| What medications are you currently on? |
| Previous complaints / surgeries? |
| Previous diagnoses / medications? |

| **COMPLAINT** | |
|---|---|
| What is your major complaint? | |
| Start date | Possible cause |
| Symptoms | |
| Previous doctors seen for complaint | |
| Previous treatment for complaint | |
| Symptoms-Aggravating factors | |
| Symptom-Relieving factors | |
| Time of day symptoms are best | Time they are worse |
| Current duration of pain □ Intermittent □ Constant □ With certain motions | |
| Please rate your pain Best (0-10) _____ Worst (0-10) _____ Average (0-10) _____ | |
| Is your pain getting better or worse? | Have you had this injury before? |

| **DO YOU HAVE ANY OF THE FOLLOWING TODAY? (CHECK ALL THAT APPLY)** | | | |
|---|---|---|---|
| □ AIDS / HIV | □ Anemia | □ Angina | □ Arteriosclerosis |
| □ Arthritis | □ Asthma | □ Blood Clots | □ Bone Infection |
| □ Cancer | □ Chemical Dependency | □ Circulation Problems | □ Depression |
| □ Diabetes | □ Epilepsy | □ Eye Infection | □ Heart problems |
| □ Hemophilia | □ High/Low blood pressure | □ Joint/Bone Infection | □ Liver problems |
| □ Lung Disorder | □ Multiple Sclerosis | □ Musculoskeletal problems | □ Pneumonia |
| □ Stroke | □ STD | □ Tuberculosis | □ Urinary infection |

** I hereby certify that all information is true and correct to the best of my knowledge, and I am responsible for all charges incurred for these services. I hereby authorize the release of any medical information necessary to process my claim and authorize my insurance company to pay Plumas Physical Therapy Inc. directly for services.*

** I understand that incomplete or incorrect information on this form may result in the inability to bill insurance for services rendered, thus resulting in charges billed directly to me.*

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE