Springfield Physical Therapy
2221 Grube Street
Springfield, OH 45503
Phone: 937-399-8941 Fax: 937-399-5639

Patient Information:

Last Name: ________________________ First Name: ________________________ Gender: ________

Date of Birth: ________________________ SS#: ________-________-________

Address: ____

City: __________________________ State: ____________________________ Zip:________________

Preferred #: ( ) __________________________ ☐ Home ☐ Work ☐ Cell

Email: ____

Marital Statue: Single: _____ Married: _____ Divorced: _____ Widowed: _____ Domestic Partner: _____

Employer's Name: _____________________________________ Occupation:_____________________

Physician's Name: _____________________________________ Diagnosis: ______________________

Injury: Work or Auto Related? _____________ Allergies or Medical Precautions: ____________________

Emergency Contact: __________________________________ Phone #: ( ) __________________

Insurance Information:

Insurance Co. Name: _____________________________________ Policy #: _____________________

Address: _______________________________City: __________________ State: _______ Zip: _______

Insured's Name: _____________________________ SS# _____-_____-_____ Date of Birth:__________

Address: _______________________________City: __________________ State: _______ Zip: _______

Insured's Employer's Name:____

I hereby accept responsibility for the cost of this examination or treatment in the event that the Insurance Company denies this claim. I hereby understand and agree to accept responsibility of the cancellation policy of this office: Giving 24 hour notice to cancel: If I am unable to comply but reschedule the appointment before and within the end of the week, no charge will be made. Otherwise a $25.00 fee will be charged for the missed session. (Please note that <u>it is your responsibility - Insurance companies do not reimburse for missed appointments</u>.)

Patient's Signature: ____

Date: _________________________________

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PATIENT QUESTIONNAIRE/HISTORY

Name: __________________________ Date of Birth: ___________________ ___ Right or ___ Left handed

What is your Chief Complaint and how has it affected your daily life?______________________________

____

Have you had any diagnostic imaging? ____

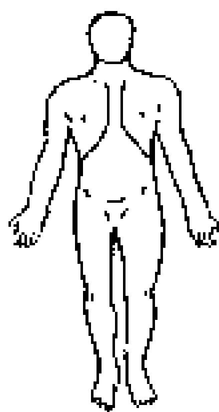
Rate your chief complaint in order of severity from worst (5) to least (1)

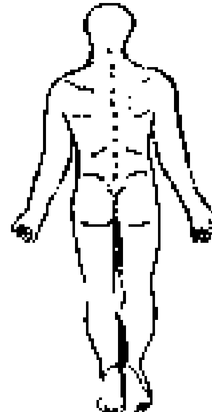
Pain _____ Decreased Motion _____ Swelling/edema _____ Stiffness _____ Loss of Function _____

Where is your problem? Indicate on the body chart. Pain: XXX Numbness: OOO Tingling: ZZZ

Indicate the nature of your pain and Symptoms: ___Sharp ___Dull ___Piercing ___Shooting ___Aching

___Deep ___Superficial ___Tingling ___Numbness ___Intermittent ___Burning ___Stabbing





When and how did this problem begin? ____

____

What makes your symptoms/pain worse?____

____

What makes you symptoms/pain lessen? ____

____

Rate your pain on a visual scale (0-10) 0 no pain 10 excruciating pain:______________________________

Worst it has been: _____Past 2 to 4 weeks _____Past 24 hours _____At this moment

Are your symptoms worse in the: _____Morning _____Afternoon _____Evening _____Inconsistent

Are Your Symptoms: _____Improving _____Worse _____Stable