



PATIENT INFORMATION **EMAIL ADDRESS:** _____

First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	Male Female	S.S. #: - -
Home Phone: () -	Alternative Phone (Cell, Pager): () -	Spouse:	
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:	
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 SG Mikita PT. I understand that I am financially responsible for any balance. I also authorize SG Mikita PT to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE

DATE

PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE	YES	NO	JOINT CONDITIONS	YES	NO
Hypertension			Upper Extremity		
Low Blood Pressure			Dislocation		
Normal Blood Pressure			Lower Extremity Dislocation		
HEART DISEASE	YES	NO	OTHER CONDITIONS	YES	NO
Heart Attack			Muscular Dystrophy		
Atherosclerotic Disease			Rheumatoid Arthritis		
Myocardial Infarction			Multiple Sclerosis		
Rheumatic Heart Disease			Epilepsy		
Heart Murmur			Gout		
Do you have a pacemaker			Fibromyalgia		
MUSCLE CONDITION	YES	NO	Diabetes		
Carpal Tunnel R/L			Hearing Loss		
Tennis Elbow R/L			Poor Eyesight		
Back/Neck Problems			Fainting		
Limited Limb Movement			Cancer (presently or history of)		
LUNGS	YES	NO	Other:		
Asthma			_____		
Emphysema			_____		
Shortness of Breath			_____		

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: _____

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 or Massage 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
MMM
M

Burning

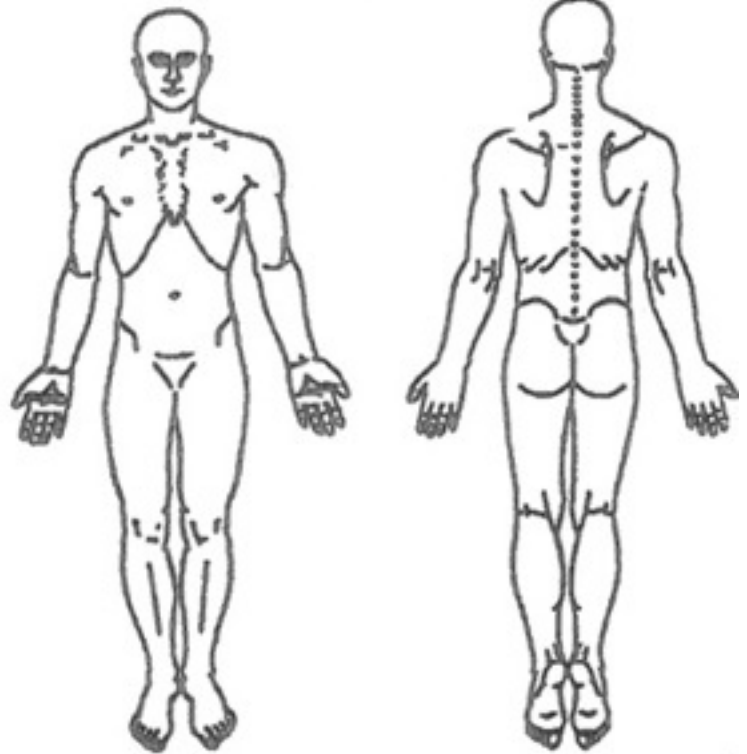
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Numbness
OOOO
OOO

Fins and Needles
□□□□□□□□
□□□□□□□□

Stabbing
/////

Other
xxxx
xxx



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 **CURRENT** 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 **AVERAGE** 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 **WORST** level of pain:

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

Additional Comments: _____