

PATIENT ADMISSION FORM

Account number: 317856 Appointment Date: 07/23/25 12/01/2025  
 Chart Number: TH02025-47892 Physical Therapist: Daniel Park, DPT  
 Referring Physician: Dr. Emily Carter, MD Phone #: 555-369-1472  
 Referring Physician NPI#: 1234567890 Fax #: 555-369-1473

For Office Use Only

DATE 12/01/25

HOME PHONE # \_\_\_\_\_ CELL PHONE # \_\_\_\_\_ OTHER PHONE # \_\_\_\_\_

NAME Michael R. Thompson SOCIAL SECURITY # \_\_\_\_\_

MAILING ADDRESS 124 Maplewood Dr. CITY Springfield STATE IL ZIP 62704

BIRTH DATE 05/12/1978 AGE 47 STATUS (circle one): S M W D SEX (circle one) M F

SPOUSE'S NAME Sarah Thompson SPOUSE'S S.S.# \_\_\_\_\_ D.O.B. \_\_\_\_\_

MAJOR COMPLAINT/DIAGNOSIS Left foot pain after fall; possible fracture

DATE OF ACCIDENT/INJURY 11/30/25 TYPE (circle one): WORKER'S COMP AUTO OTHER

EMERGENCY CONTACT Sarah Thompson PHONE # 555-246-8137

EMPLOYER NAME \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_

EMPLOYER PHONE \_\_\_\_\_

NEXT DOCTOR'S APPOINTMENT (date) 12/12/25

PRIMARY INSURANCE BCBS Illinois POLICY ID # 987654321

POLICY HOLDER Michael R. Thompson POLICY HOLDER S.S.# \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_ POLICY ID # \_\_\_\_\_

POLICY HOLDER \_\_\_\_\_ POLICY HOLDER S.S.# \_\_\_\_\_

Have you received any physical therapy services this year? (circle one) Y N If yes, how many visits? 0

Who is responsible for this bill? Michael R. Thompson

Will you be paying by (circle one) CASH CHECK CREDIT CARD

I acknowledge the above information is true and correct. I hereby authorize treatment and understand the possible benefits and risks of treatment. I irrevocably assign all benefits to LSU-HSC Physical Therapy Clinic. I authorize release of medical records to my doctor and insurance company. If my reason for seeking treatment is the result of a work-related or personal injury claim, I also release information to my attorney, claims adjustor and my employer. I also authorize any physician or medical facility to release information relevant to LSU-HSC Physical Therapy Clinic. I understand and agree that (regarding my insurance status), I am ultimately responsible for the balance of my account for any professional services.

PATIENT'S SIGNATURE: My...  
M. R. Thompson DATE 12/01/25

PLEASE PRINT LEGIBLY

Patient Name Michael R. Thompson

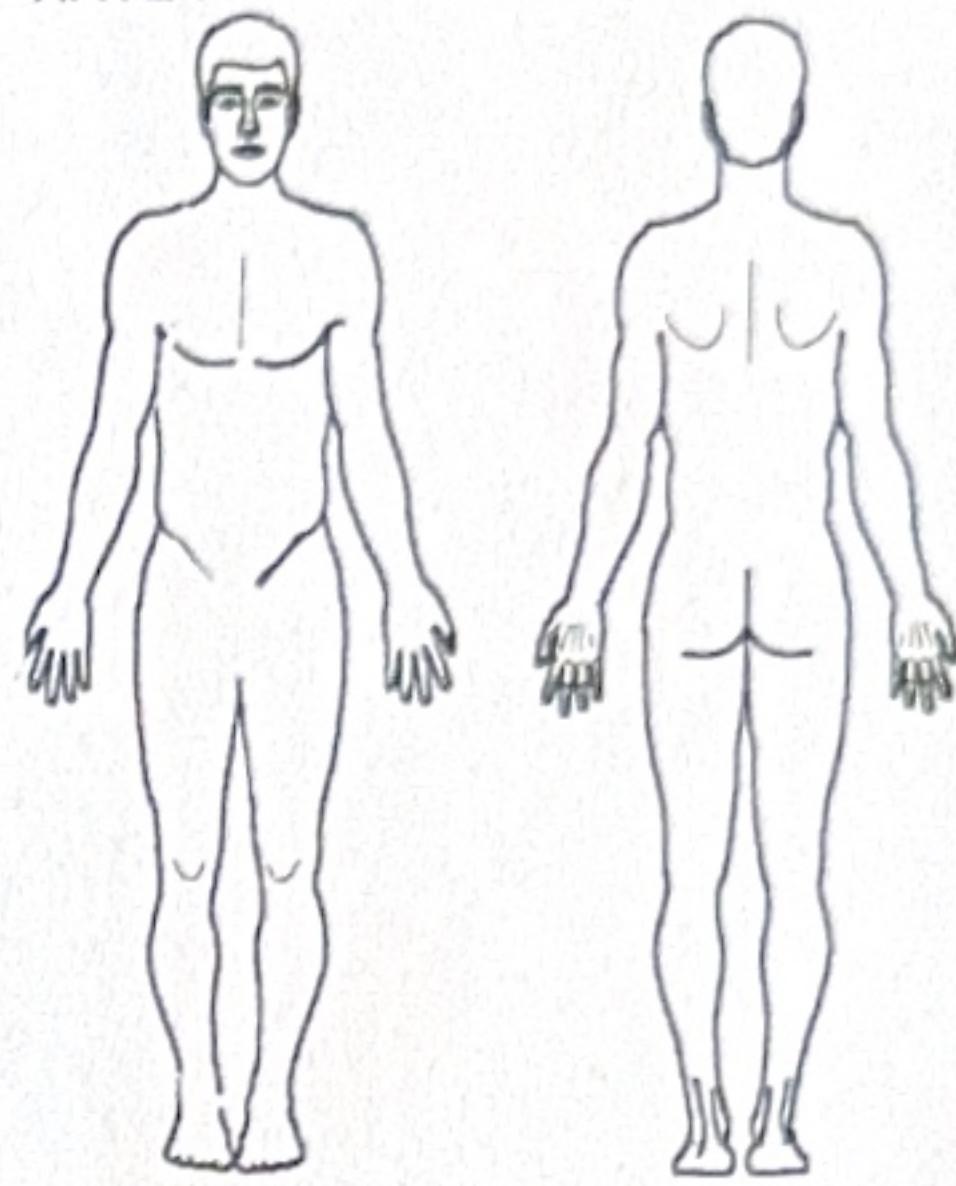
Patient, please complete the following questions regarding how you feel today and in the past week.

1. How do you feel today?

Circle your pain level today.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



In the past week, how often have your symptoms been present?

0-25%  26-50%  51-75%  76-100%  None

Circle your average pain level over the past week.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

Circle your worst pain level over the past week.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

Currently, how much has your pain interfered with your daily activities?

No Interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

What are your goals for your acupuncture treatments?

Pain relief

How do you track your progress towards your goals?

Pen ~~Chart~~ Measure pain

What progress has been made toward your goals?

Little to no progress

2. Are you getting better?

Current Condition(s)/Complaint(s)

1 Fractured foot

Rate your overall progress since starting acupuncture

Excellent  Good  Fair  Poor  Worse

2 \_\_\_\_\_

Excellent  Good  Fair  Poor  Worse

3 \_\_\_\_\_

Excellent  Good  Fair  Poor  Worse

3. Which type(s) of treatment have been helpful to your condition(s)?

Acupuncture treatment

Nutritional supplements

Rehab Exercise/Home Care

Chinese herbs

Prescription Medication(s)

Spinal Adjustment/Manipulation

Therapeutic Massage

Physical therapy

Other \_\_\_\_\_

4. Is there anything new?

Have you had any new complaints/conditions?  No  Yes Explain \_\_\_\_\_

Have you had any re-injuries or events that have prolonged your recovery?  No  Yes

Explain \_\_\_\_\_

Are you pregnant?  No  Yes; How many weeks? \_\_\_\_\_ Are you under a physician's care?  No  Yes

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature Michael R. Thompson

Date

12/01/25



Kitty Wilde RN Case Manager

# Vital Signs Flow Sheet

Foot X-ray

