BENTON CITY PHYSICAL THERAPY

604 Ninth St. P.O. Box 840, Benton City, WA 99320 • Phone 509-588-2924 • FAX 509-588-4564

For official use only:
Physical Therapist _____
Diagnosis Code(s):

Patient's Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____ E-mail: _____

Date of Birth: _____ ☐ Male ☐ Female SSN: _____

Employer: _____ ☐ Student Work Phone: _____

Employer's Address: _____ City: _____State: _____ ZIP: _____

Referring Physician: _____ Physician's Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

If Married: **Spouse's Name:** _____ Employer: _____

Cell Phone : _____ Work Phone: _____

PLEASE COMPLETE IF PATIENT IS A MINOR:

Mother/Guardian's name: _____ Address: _____

City: _____ State: _____ Zip: _____ DOB: _____

Employer: _____Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Father/Guardian's name: _____Address: _____

City: _____ State: _____ Zip: _____ DOB: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone:_____

Insurance Information

Primary_____

Address_____

Subscriber Name_____

Membership Number_____

Group Number_____

Secondary_____

Address_____

Subscriber Name_____

Membership Number_____

Group Number_____

Date of Injury_____

Claim Number_____

___ Job ___Auto ___Accidental

Emergency Contact Name: _____ Phone: _____

I authorize Columbia Physical Therapy, Inc. P.S. to use and disclose health and medical information for the purposes of treatment, payment and health care operations. Under all circumstances I assume final responsibility for my account understanding that in the event my account becomes delinquent, I agree to pay accrued finance charges, court costs and attorney fees. I consent to physical therapy services prescribed by any physician. I authorize payment of medical benefits by my insurance company to Columbia Physical Therapy, Inc. PS, for services rendered. I have received this practice's Notice of Privacy Practices written in plain language.

Signature: _____ **Date:** _____

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Office Use Only
BP:_____ Height:_____
SPO2:_____ Weight: _____
HR:_____
Temp:_____

Patient History

Name_____Date_____

1. What is your problem or injury _____
2. How did your problem or injury begin? _____
3. How long ago did it begin? _____
4. What is your type of work? _____
5. Are you working? . . . . . ☐ Yes ☐ No
   If no, is it because of your problem? . . . . . ☐ Yes ☐ No
6. Before this injury were you completely free of symptoms? ☐ Yes ☐ No
7. Have you ever had anything similar before? . . . . . ☐ Yes ☐ No
8. What, if any, treatments have you had for this current problem?
   Check one: ☐ Physical Therapy ☐ Chiropractic ☐ Medical ☐ Other
9. What eases your pain? ☐ Sitting ☐Standing ☐Walking ☐Lying Down
10. What makes your pain worse? ☐ Sitting ☐Standing ☐Walking ☐ Lying Down
11. Do you have any feelings of pins and needles or numbness?
    ☐ Yes ☐ No
12. Do you have any other problems?
    ☐ Yes ☐ No
13. Are you taking any medications?
    ☐ Yes ☐ No

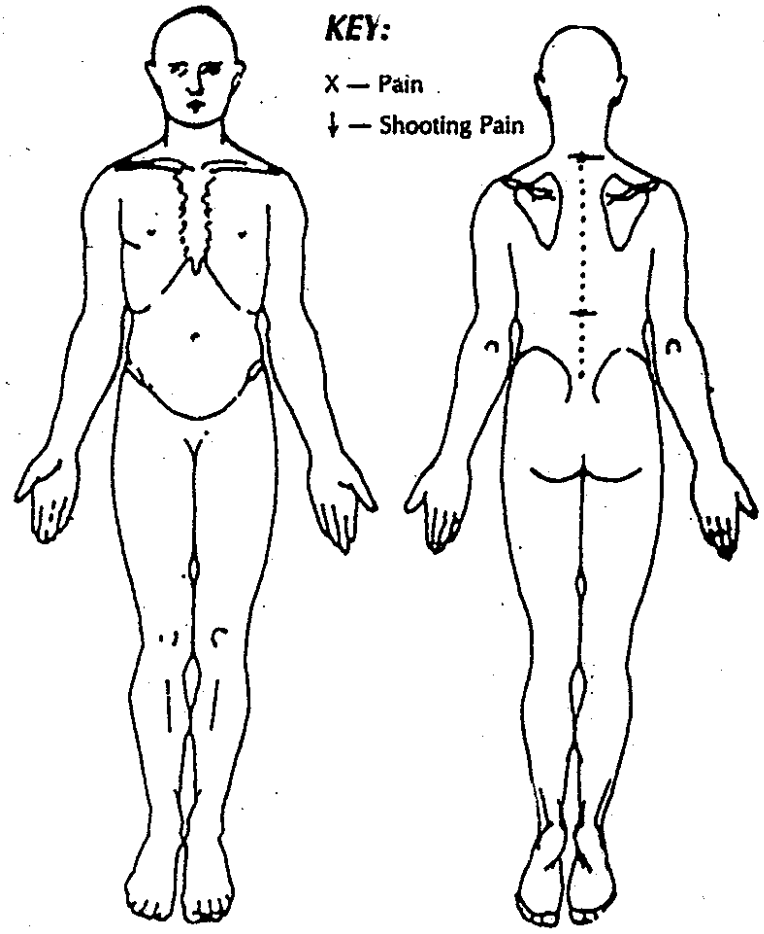
Please list:

_____

_____

_____

14. Show on the body figure the places of discomfort.



Medical History Questionnaire

Name: _____ Date: _____ Age: _____ Gender: M / F
Right or Left Handed _____ Occupation: _____
Leisure activities: _____

Please rate your health: Excellent Good Fair Poor

Do you exercise beyond normal daily activities and chores? Yes No
If yes, please describe the exercise: _____
On average how many days per week do you exercise? _____
How many minutes per exercise session? _____

Medical History
Have you EVER been diagnosed as having the following condition(s)? Please check all that apply.

- Stroke
- Migraines
- High blood pressure
- Emphysema
- Tuberculosis
- Rheumatoid arthritis
- Kidney disease
- Hepatitis
- Thyroid problems
- Digestive problems
- Unexplained falls
- Genetic disorders
- Stomach/ulcer problems
- Developmental/Growth problems
- Repeated infections
- Seizure disorders
- Depression
- Heart condition
- Asthma
- Diabetes/High blood sugar
- Low blood sugar
- Other arthritic disease
- Circulatory problems
- Skin problems
- Bowel or bladder problems
- Cognitive dysfunction
- Multiple sclerosis
- Osteoporosis
- Anemia
- Chemical dependency (e.g. alcoholism)
- Allergies: Specify: _____
- Cancer: Specify: _____
- Other neurologic problems: Specify: _____
- Other: _____

Are you pregnant or think you might be pregnant? Yes No

Surgical History
Please list all surgeries/hospitalizations including dates and reasons.

Date	Surgery/hospitalization/reason
_____	_____
_____	_____
_____	_____

Are you being or have you been treated for musculoskeletal injuries (fracture, dislocations, repetitive strains, joint instability)?
If so, please state:

Date	Injury
_____	_____
_____	_____

Please list any PRESCRIPTION medications you are currently taking (include pills, injections, patches, etc.)

_____
_____
_____

Please list any OVER-THE-COUNTER MEDICATIONS you are taking:

_____
_____
_____

Within the past year, have you had any of the following symptoms (Check all that apply)

- Nausea/vomiting
- Dizziness
- Fever
- Unexplained weight loss/gain
- Night sweats
- Diarrhea/Constipation
- Unexplained sweating
- Unexplained fatigue
- Unexplained paleness
- Chest Pain
- Loss of Balance
- Hoarseness
- Tremors
- Infection
- Coordination Difficulty
- Loss of appetite
- Difficulty swallowing
- Vision problems
- Cough
- Difficulty walking
- Headaches
- Difficulty sleeping
- Chills
- Blackouts
- Shortness of Breath
- Joint pain or swelling
- Pain at night
- Hearing problems
- Heart palpitations
- Weakness in limbs
- Urinary problems

Family History
Has anyone in your family (parents, sisters, brothers, grandparents) ever been treated for any of the following:

- Stroke
- Parkinson's disease
- Mental illness
- High blood pressure
- Breathing problems
- Arthritic disease
- Anemia
- Thyroid problems
- Learning disabilities
- Genetic disorders
- Seizure disorder
- Multiple sclerosis
- Cancer
- Heart condition
- Diabetes
- Kidney Disease
- Vascular problems
- Skin problems
- Cognitive dysfunction
- Chemical dependency (e.g. alcoholism)
- Other neurologic problems: Specify: _____

How much caffeinated coffee or other caffeinated beverages Do you drink per day? (number of cups/cans/bottles) _____

Do you smoke? Yes No
If yes: How many packs per day? _____

Do you drink alcohol?
If yes: How many days per week do you drink? _____
If yes: How many drinks per sitting? _____
(Note: one beer or one glass of wine equals 1 drink)

If you use marijuana or other substances, how often? ____ dy/wk

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WELCOME TO BENTON CITY PHYSICAL THERAPY

Thank you for choosing Benton City Physical Therapy
for your physical and occupational therapy care!

Our goal is to provide you with the highest quality care
in a professional and caring atmosphere.

We encourage you to take an active role in your recovery process. Your treatment will be tailored to your specific needs; however, open, honest communication is the only way this will happen effectively. If you have questions concerning your diagnosis or are uncomfortable with any part of your treatment, please let us know. We are open to feedback and will make any necessary changes to make your recovery process as pleasant as possible. If you have any personal goals you would like to accomplish or specific activities you would like to return to, we would like to incorporate them into your treatment goals, as well.

We request that you give us 24 hours notice when you are unable to attend your scheduled treatment session. This courteous act will allow another client time, from our waiting list, to be seen in the open treatment spot. We understand that unavoidable conflicts may occasionally occur.

Please understand that you are responsible to know your insurance benefits and if a co-pay is required.

Again, if you ever have any questions or concerns, we are here for you. We hope to exceed your expectations, here, at Benton City Physical Therapy and are pleased to work with you on a speedy recovery.

Carter

Carter Lake
Physical Therapist
Occupational Therapist

Lacy

Lacy Torres
Office Manager
PT Aide

Carol

Carol Ritchie
PT Aide

I have read and understand the above information. I will ask for clarification if I have any questions concerning my treatment and will take responsibility for my recovery progress and for knowing my insurance benefits and copay.

_____ _____

Client's name Date