



PATIENT INFORMATION

Name: _____ SSN#: _____
First MI Last (REQUIRED FOR WORK COMP)

Male Female Date of Birth ___/___/___ Marital Status: Single Married Divorced Widowed

Address: _____
Street Address City State Zip

Email Address: _____ Cell Phone: (____) ____ - _____

Would you like to receive appointment reminders by email?

Yes, notify me by email No, Do not email me

Emergency Contact: _____

Phone# _____

Claim #: _____

Employer: _____

At time of Injury

Employer Address: _____
(City Required) Street Address City State Zip

Referring Physician: _____ City: _____

CONSENT FOR TREATMENT

I the Undersigned do hereby agree and give my consent for **Rancho Physical Therapy** to furnish physical therapy care and treatment considered necessary and proper in evaluating and/or treating my physical condition. It is your responsibility to notify our office of any patient information changes (i.e., address, phone number, name, insurance information, etc.)

Signature: _____ Date: _____

NON-COMPLIANCE NOTIFICATION

Your therapist, physician, adjuster, and case manager work together to assist with your return to full function in the workplace. In order for your treatment to have maximal effect and progress, all prescribed therapy sessions must be attended. To comply with the workers' compensation laws, we are required to notify the adjuster, case manager and physician of missed appointments. If for any reason, you are unable to attend, please call in a timely manner and we will reschedule your appointment and inform your adjuster. Missed appointments may result in discontinuation of workman's compensation benefits.

Signature _____ Date _____



**WORKERS' COMPENSATION CARRIER/ ATTORNEY & ADJUSTER
INFORMATION**

Carrier: _____ Adjuster's Name _____ Adjuster Phone: (____) ____ - ____

Claims Mailing Address: _____
Street Address City State Zip

Attorney Name: _____ Attorney Phone (____) ____ - ____

Mailing Address: _____
Street Address City State Zip

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY
PRACTICES AND AUTHORIZATION OF RELEASE OF
SPECIFIC INFORMATION**

Rancho Physical Therapy reserves the right to modify the privacy practices outlined in this notice.

**I acknowledge that I have received or have had the opportunity to receive a copy of the
official Notice of
Privacy Practices from Rancho Physical Therapy, Inc.**

Signature: _____ Date: _____

By signing this authorization, I understand that this does not authorize release of medical information by Rancho Physical Therapy, Inc. to any other organization or agency unless I grant further authorization. I also understand that these authorizations may be revoked at anytime.

Signature: _____ Date: _____

Initial all statements that apply:

_____ I authorize you to leave messages regarding my appointments on my answering machine or voicemail as listed on my patient information.

_____ I authorize you to discuss my appointments with my spouse as listed on my patient information.

_____ In addition to my referring doctor, I authorize you to communicate with and send reports & evaluations to the following:

_____ I agree to enroll in the electronic statement service and consent to receive my periodic account statements electrically



HEALTH HISTORY

Patient Name: _____ Height _____ Weight _____ Date of Birth ____/____/____

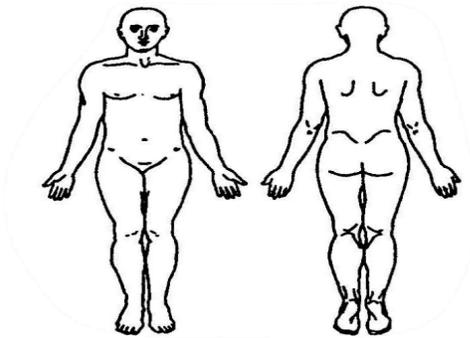
CURRENT COMPLAINTS

Did your injury result in surgery? If so, what was the date of surgery ____/____/____

Have you ever had a similar injury/condition in the past? _____

Is your injury/condition **getting better**, **staying the same**, or **getting worse**? (Circle one)

Please mark **X's** on the figure where your current symptoms are located



Please circle your current symptoms below

Sharp	Aching
Numbness	Pulling
Tingling	Heavy
Dull	Burning
Shooting	Throbbing
Stabbing	Other: _____

Rate your pain level over the last week at its best and at its worst on the scale below

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 **UNBEARABLE PAIN**

On the percentage scale below, circle your current level of overall function

NO RESTRICTIONS 100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0% **UNABLE TO FUNCTION**

Do you have any work restrictions Yes No

If no, please list any specific limitations you have due to your current condition: _____



MEDICAL HISTORY

Please circle YES for applicable conditions. Or NO for all conditions.

Allergies	Yes	No	Diabetes	Yes	No	Metal Implants	Yes	No
Anemia	Yes	No	Dizzy Spells	Yes	No	MRSA	Yes	No
Anxiety	Yes	No	Emphysema/Bronchitis	Yes	No	Multiple Sclerosis	Yes	No
Arthritis	Yes	No	Fibromyalgia	Yes	No	Muscular Disease	Yes	No
Asthma	Yes	No	Fractures	Yes	No	Osteoporosis	Yes	No
Autoimmune Disorder	Yes	No	Gallbladder Problems	Yes	No	Parkinsons	Yes	No
Cancer	Yes	No	Headaches	Yes	No	Rheumatoid Arthritis	Yes	No
Cardiac Conditions	Yes	No	Hearing Impairment	Yes	No	Seizures	Yes	No
Cardiac Pacemaker	Yes	No	Hepatitis	Yes	No	Smoking	Yes	No
Chemical Dependency	Yes	No	High Cholesterol	Yes	No	Speech Problems	Yes	No
Circulation Problems	Yes	No	High/Low Blood Pressure	Yes	No	Strokes	Yes	No
Covid-19	Yes	No	HIV/AIDS	Yes	No	Thyroid Disease	Yes	No
Currently Pregnant	Yes	No	Incontinence	Yes	No	Tuberculosis	Yes	No
Depression	Yes	No	Kidney Problems	Yes	No	Vision Problems	Yes	No

Describe any other conditions:

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Medical Precautions:



FALL HISTORY

Injury as a result of a fall in the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Fall: _____
Two or more falls in the last year? Patient is at risk for fall? Yes No N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dates of Falls: _____

SURGICAL HISTORY

related to the current condition

Body Region: _____	Surgery Type: _____	Date of Surgery: _____
Body Region: _____	Surgery Type: _____	Date of Surgery: _____
Body Region: _____	Surgery Type: _____	Date of Surgery: _____

CURRENT MEDICATIONS

Drug	Dosage	Frequency	Route	Reason for Taking