AQUACARE FITNESS FORUM PHYSICAL THERAPY

Welcome to Aquacare Physical Therapy
Patient Information

Today's Date:		Date of Birth:	
First Name:	Middle Initial	Last Name:	
Name Preference (Nickname):		Preferred Pronoun(s):	
Gender on your ID or Insurance Card (Circle One):	MALE	FEMALE	

Contact Details

Street Address/P.O. Box:		City:	State:	Zip Code:
Mobile Phone:	Home Phone:	Email:		
How do you prefer to receive any patient statements (circle all that apply):		Mail	Email	
How did you hear about us?				

Emergency Contact(s):

First Name:		Last Name:
Mobile Phone:	Home Phone:	Relationship to patient:

Guarantor (if any):

First Name:		Last Name:		
Mobile Phone:	Home Phone:	Relationship to patient:		
Street Address/P.O. Box:		City:	State:	Zip Code:

Appointment Preferences:

What are your preferred days and times to come to treatment?

Please mark an X on all the day and time ranges that are optimal for you to come to treatment. This does not guarantee that there will be availability at these days/times but it will enable our team to schedule you at your preferred times.

Days/Times:	Before 8am	8am – Noon	Noon – 3pm	3pm - 5pm	After 5pm
Mon					
Tues					
Wed					
Thurs					
Fri					
Sat					

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Payment Details:

Are you using insurance (circle one): Yes No

If yes, please add your insurance information below:

Primary Insurance:

Insurance Carrier:	Member ID:	Group/Plan # (if any):	Patient's Relationship to Insured:	
First Name (Of Insured)):	Last Name (Of Insured):	Date of Birth (Of Insured):	Gender (Of Insured on Insurance):	
If the insured address is different than patient's:	Street Address/P.O. Box:	City:	State:	Zip Code:

Secondary Insurance (if applicable):

Insurance Carrier:	Member ID:	Group/Plan # (if any):	Patient's Relationship to Insured:	
First Name (Of Insured)):	Last Name (Of Insured):	Date of Birth (Of Insured):	Gender (Of Insured on Insurance):	
If the insured address is different than patient's:	Street Address/P.O. Box:	City:	State:	Zip Code:

Are you currently receiving, or have you received within the last year any of the following? (circle all that apply)

Home Healthcare Services	Chiropractic Care	Physical Therapy

If so, where: _____

Injury Details:

Relevant Injury Dates

What date did you first experience symptoms related to your injury? _____

If you had surgery for this issue, what was the date of the most recent surgery? _____

If you started treatment at another facility on an earlier date, please add that date here. _____

Injury Info

Is your injury work related? **Yes** **No** Is your injury auto related? **Yes** **No**

Doctor Info

Height (in inches): Weight (in lbs):

Patient Reported Issues

Describe how your condition came to be. What events occurred? When did the symptoms start? How has it progressed over time?

What is the main reason you are seeking medical attention? What problem can we help you solve?

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Goals List - Select any of the goals you have for this treatment below. You can add additional goals in the text area below the selections.

☐ Return to Normal Mobility	☐ Reduce pain to improve overall function	☐ Perform all Activities of Daily Living without pain	☐ Walk long distances without pain	☐ Stand for prolonged period of time without pain
☐ Sit for prolonged period of time without pain	☐ Perform flight of stairs without pain and good function	☐ Sleep without disturbances or pain	☐ Dress independently without pain and improved function	☐ Reduce dizziness
Additional Goals:				

Problems List - Select any of the goals you have for this treatment below. You can add additional problems in the text area below the selections.

☐ Difficulty with walking	☐ Difficulty with seated transfers	☐ Difficulty with standing up	☐ Difficulty with sitting balance	☐ Difficulty with standing balance	☐ Difficulty with lifting of objects
☐ Difficulty with carrying of objects	☐ Difficulty with lifting/placing objects overhead	☐ Difficulty with bed mobility	☐ Difficulty with dressing of the arm	☐ Difficulty with dressing of the leg	☐ Difficulty with performance of stairs
☐ Difficulty with sitting for prolonged periods of time	☐ Difficulty with standing for prolonged periods of time	☐ Pain with intercourse	☐ Pain with bowel movements	☐ Urinary incontinence	☐ Fecal incontinence
☐ Additional Problems:					

Do you have a history of falls? Yes No

If so, what is the date of the most recent fall and the details of the fall.

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Medical History

Have you ever suffered from or been told you have any of the following? (select all that apply)

☐ High blood pressure	☐ Heart problems	☐ Lung problems	☐ Head injury	☐ Multiple sclerosis	☐ Ulcers/stomach problems
☐ Liver problems	☐ Thyroid problems	☐ Blood disorders	☐ Diabetes	☐ Low blood sugar	☐ Stroke
☐ Osteoporosis	☐ Parkinson's disease	☐ Cancer	☐ Chronic pain	☐ Circulatory or vascular problems	
☐ Chronic migraines	☐ Arthritis	☐ Other orthopedic problems		☐ Broken bones (fractures)	

Have you recently experienced any of the following? (select all that apply)

☐ Weight loss	☐ Weight gain	☐ Pain at night	☐ Fatigue/malaise
☐ Difficulty sleeping	☐ Joint pain	☐ Joint swelling	☐ Urinary problems
☐ Bowel problems	☐ Nausea and vomiting	☐ Numbness or tingling	☐ Weakness in your arms or legs
☐ Coordination problems	☐ Difficulty walking	☐ Dizziness or loss of consciousness	☐ Chest pain
☐ Heart palpitations	☐ Short of breath	☐ Difficulty swallowing	☐ New onset of headaches
☐ Visual problems	☐ Hearing problems	☐ Use of a pacemaker	☐ Denies presence of any physical symptoms

Do you do any of the following? (select all that apply)

☐ Smoke	☐ Drink alcohol	☐ Have any significant family history of illness or disease

Who have you seen for your condition before today?

☐ Medical Doctor	☐ Massage Therapist	☐ Chiropractor	☐ Athletic Trainer
☐ Physical Therapist	☐ Acupuncturist	☐ Occupational Therapist	☐ Speech Therapist
☐ I have not been seen for my condition before today			

Please describe what the other people you have seen told you or did for your injury.

Please list any medications you are currently taking with the name, dosage, frequency, and the method that you take it.

Please list any known allergies that you have.

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Pain Measurements

Are you currently experiencing pain? Yes No

If yes, please answer the following:

1. What body part(s)?										
2. On what side of the body is your injury/condition?	Left			Right			Bilateral			N/A
3. How would you describe the injury's severity?	Chronic						Acute			
4. What is the pain at its best, with "0" being the least amount of pain and "10" being the most pain?	0	1	2	3	4	5	6	7	8	9	10
5. What is the pain at currently, with "0" being the least amount of pain and "10" being the most pain?	0	1	2	3	4	5	6	7	8	9	10
6. What is the pain at its worst with "0" being the least amount of pain and "10" being the most pain?	0	1	2	3	4	5	6	7	8	9	10

How would you describe the pain? Select all options that apply.

☐ Burning	☐ Sharp	☐ Aching	☐ Throbbing	☐ Shooting
☐ Dull	☐ Tingling	☐ Constant	☐ Intermittent	☐ Numbness
☐ Worse in AM	☐ Worse in PM	☐ Dizziness		

What actions make the pain worse? Select all options that apply.

☐ Sitting	☐ Standing	☐ Walking	☐ Going upstairs
☐ Going downstairs	☐ Exercising	☐ Bending	☐ Reaching/Extending
☐ Lying down	☐ Applying Pressure	☐ Coughing/Sneezing	☐ Falling

What functions make the pain less? Select all options that apply.

☐ Resting	☐ Icing	☐ Compression	☐ Distraction	☐ Massaging	☐ Heat

Please describe the pain briefly.

I certify to the best of my knowledge the above information is correct. I understand I will be provided with a description of my individualized physical therapy treatment plan. It will include the potential benefits and any associated risks of physical therapy. I understand that my attendance, in accordance with the prescribed treatment plan, is critical to maximizing the potential benefits of my physical therapy treatment plan. I have read and understand the above information and agree to consent to physical therapy treatment to be provided by Aquacare Physical Therapy personnel.

Signature: _____ Date: _____

☐ Patient ☐ Legal Guardian ☐ Power of Attorney