ATLAS THERAPY

Name: _____ Date of Birth: _____ Date: _____

Home Phone Number: _____ Mobile Phone Number: _____ Email: _____

Billing Address: _____

_____

Emergency Contact: _____ Phone Number:_____ Relationship: _____

Age: _____Height: _____ Weight: _____

Gender: Male Female Non-Binary/Third Gender Prefer to Self-Describe Prefer Not to Say

How did you hear about us?

Doctor	Friend/Family	I've had PT here before
Google Review	Website	Other:

Tell us about your injury or symptoms:
Injury Date: _____Physician Diagnosis: _____
How it occurred: _____

What region(s) are affected by your current symptoms?

Head/Neck	Upper Back	Shoulder	Arm	Hand/Wrist	Hip
Pelvis	Lower Back	Knee	Leg	Ankle/Foot	Other:

What kind of symptoms are you experiencing?

Tenderness	Spasm	Numbness	Tingling	Aching
Sharp	Shooting	Dull	Other:	

When are the symptoms/pain worse?

In the morning	During the day	At night	With activity
At rest	None	Come and go	Constant

When are the symptoms/pain at it best?

In the morning	During the day	At night	With activity
At rest	None	Come and go	Constant

Please indicate the intensity of pain levels over the past 24 hours on a scale of 0 (no pain) to 10 (worst pain imaginable).
Current: _____ Best: _____ Worst: _____

If you had any testing for this issue, circle all that apply and provide the results if able.
X-Rays: Results : _____ **MRI**: Results : _____
CT Scan: Results : _____ **Other**: Results : _____
EMG/Nerve Conduction Test: Results : _____

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Have you had surgery for this issue? NO YES (Date): _____ What?_____

Have you ever had any treatment for this issue?

Medication	Beneficial?	YES	NO	Explain: _____
Injection	Beneficial?	YES	NO	Explain: _____
Physical Therapy	Beneficial?	YES	NO	Explain: _____
Occupational Therapy	Beneficial?	YES	NO	Explain: _____
Massage/Chiropractic	Beneficial?	YES	NO	Explain: _____
Other	Beneficial?	YES	NO	Explain: _____

Have you fallen within the last year? YES NO
Do you feel unsteady when standing or walking? YES NO
Do you worry about falling? YES NO

Please circle the conditions that you have been or are presently being treated for. This information helps your therapist develop a treatment plan that will be best for you.

Acquired Respiratory Distress Syndrome
Allergies
Anemia
Angina
Anxiety or Panic Disorders
Arthritis
Asthma
Bleeding Disorders
Bowel/Bladder Abnormalities
Cancer
Chronic Obstructive Pulmonary Disease
Congestive Heart Failure
Defibrillator
Degenerative Disc Disease
Depression
Diabetes
Dizzy or Fainting Spells
Emphysema
Epilepsy or Seizer Disorder
Fracture
Fibromyalgia
Headaches
Hearing Impairment
Heart Attack
Heart Disease
Heart Palpitations
Hepatitis, A, B, C
Hernia
High Blood Pressure
HIV/AIDS
Hyperthyroidism
hypoglycemia
Hypothyroidism
Immunosuppressant Condition
Intolerance to Cold
Intolerance to Heat
Kidney Problems
Liver/Gallbladder Problems
Low Blood Pressure
Metal Implants
Multiple Sclerosis
Nausea/Vomiting
Night Pain
Numbness/Tingling in Hip/Buttocks
Osteoporosis
Pacemaker
Pain with Cough/Sneeze
Parkinson's Disease
Peripheral Vascular Disease
Polio
Pregnancy
Recent Dizziness/Fainting
Recent Fever
Ringing in your Ears
Sexual Dysfunction
Skin Abnormalities
Smoking
Special Diet Guidelines
Stroke or TIA
Tuberculosis
Unexplained Weight Change
Upper Gastrointestinal Disease
Urine Leakage
Visual Impairment

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Are you currently taking any medications? (Yes/No) Please list any current medications.

Name of prescription medication.	Dosage	Why are you taking this medication?	How often do you take this medication?	How do you take it? (by mouth, injection, etc.)
Over the counter medication or nutritional supplements	Dosage	Why are you taking this medication?	How often do you take this medication?	How do you take it? (by mouth, injection, etc.)

Name:_____ Date of Birth: _____ Date: _____

Is your injury related to any of the following: **Auto** Related, **Work** Related, **Other Accident** Related?

Please complete the following information if <u>Auto Related</u>:

Insurance Company Name: _____

Claim #:_____ Date of Incident: _____

Accident State: _____ Adjuster: _____

Please complete the following information if <u>Work Related</u>:

What is your employment status? Full-Time Part-Time None
Please enter your employer's information: Employer's Name: _____

Phone: _____ Address: _____

_____

What is your occupation? _____Are you currently working? _____

Please circle all that apply to your current employment duties/responsibilities/requirements:

- ☐ Sitting
- ☐ Computer Work
- ☐ Bending
- ☐ Heavy Lifting
- ☐ Traveling
- ☐ Standing
- ☐ Other: _____
- ☐ Reaching
- ☐ Crawling
- ☐ Twisting
- ☐ Pushing/Pulling
- ☐ Gripping/Pinching
- ☐ Walking

Please complete the following information if <u>Other Accident Related</u>:

Insurance Company Name: _____

Claim #:_____ Date of Incident: _____

Nurse Case Manager/Adjuster: _____

Name:_____ Date of Birth: _____ Date: _____

What are your goals for therapy? _____

_____

Are there any other issues/concerns that you think we should know about that may or may not affect your ability to benefit from physical therapy? YES: _____ NO

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____