

**PATIENT INFORMATION**

Patient's Last Name		First	Middle	How would you like to be addressed?	
Street Address		City		State	Zip Code
Home Phone	Work Phone		Cell Phone	Social Security Number (billing purposes)	
E-mail Address			Date of Birth	Age	Sex Male Female
Occupation	Employer	Employer Address			
Prescribing Physician's Name	Date of Last Physician Appt. / /	Date of Next Physician Appt. / /	How did you hear about our office?		

**INSURANCE / FINANCIAL INFORMATION**

Type of Insurance		Subscriber's Name			
Person Responsible for Bill		Responsible Party Address			
Phone Number	Student Status Full-time / Part-time	Accident Status None / Auto / Work / Other:		Date of Injury	
Workers' Compensation Claim # (If Applicable)		Claim's Adjuster	Adjuster's Phone Number		

**IN CASE OF EMERGENCY**

Contact Name	Relationship to Patient	Home Phone	Work Phone
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**DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:**

\_\_\_\_\_

\_\_\_\_\_

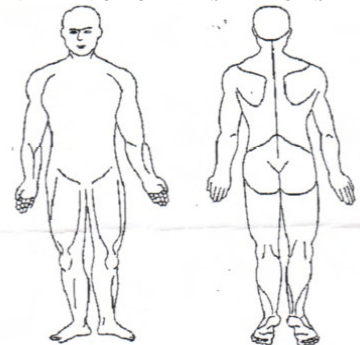
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Can you perform your daily activities? Yes No (Describe)

\_\_\_\_\_

\_\_\_\_\_

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



**Have you ever had physical therapy for this condition? Yes No Year:**

Current complaint (how you feel today):																							
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">0</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> <td style="text-align: center;">4</td> <td style="text-align: center;">5</td> <td style="text-align: center;">6</td> <td style="text-align: center;">7</td> <td style="text-align: center;">8</td> <td style="text-align: center;">9</td> <td style="text-align: center;">10</td> </tr> <tr> <td colspan="5">No Pain</td> <td colspan="6"></td> <td colspan="1">Unbearable Pain</td> </tr> </table>	0	1	2	3	4	5	6	7	8	9	10	No Pain											Unbearable Pain
0	1	2	3	4	5	6	7	8	9	10													
No Pain											Unbearable Pain												

**HAVE YOU RECENTLY NOTICED?**

Yes No Weight Loss/Gain	Yes No Weakness	Yes No Dizziness
Yes No Nausea/Vomiting	Yes No Fever/Chills/Sweats	Yes No Bladder/Bowel Changes
Yes No Fatigue	Yes No Numbness or Tingling	Yes No Chest Pain

**HAVE YOU EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS?**

Yes No Heart Problems	Yes No Hearing Loss/Disorder	Yes No Cancer
Yes No High Blood Pressure	Yes No Eye Disease	Yes No Osteoporosis
Yes No Circulation Problems	Yes No Muscular Disease/Disorder	Yes No Depression
Yes No Rheumatoid Arthritis	Yes No Multiple Sclerosis	Yes No Past Pregnancy
Yes No Other Arthritic Conditions	Yes No Tuberculosis	Yes No Current Pregnancy
Yes No Stroke	Yes No Epilepsy/Seizures	Yes No Chemical Dependency
Yes No Lung Disease	Yes No Hepatitis	Yes No Ulcers
Yes No Asthma	Yes No Kidney Disease	Yes No Other: _____
Yes No Pacemaker	Yes No Thyroid Problems	_____
Yes No Diabetes	Yes No Implanted Devices	_____

**LIST SURGERIES, MEDICAL CONDITIONS OR INJURIES FOR WHICH YOU HAVE BEEN TREATED**

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

**LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (PILLS, INJECTIONS, INHALERS, ETC.)**

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\_\_\_\_\_

\_\_\_\_\_

The above information is true to the best of my knowledge. I hereby authorize Hayashida & Associates Physical Therapy, Inc., to release any and all information concerning my care to my insurance company. I further authorize payment directly to Hayashida & Associates Physical Therapy, Inc., and I understand that I am financially responsible for all charges not covered by my insurance payments.

X \_\_\_\_\_

PATIENT/GUARDIAN SIGNATURE DATE

**HIPPA Privacy Practices Acknowledgement**  
**See attached notice on clipboard**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_