



# hayashida & associates

## physical therapy, inc.

www.hayashidapt.com

6030 Hollister Ave · Goleta CA 93117 · 2921 De La Vina Street · Santa Barbara CA 93105 · P.O. Box 30459 Santa Barbara CA 93130

Please fill out completely

Date:

### PATIENT INFORMATION

Patient's Last Name		First	Middle	How would you like to be addressed?	
Permanent Street Address			City	State	Zip Code
Primary Phone		Circle One: Cell   Home   Work		Secondary Phone	
				Circle One: Cell   Home   Work	
Date of Birth		Age		Social Security Number (billing purposes)	
/ /					
E-mail Address					
Occupation		Employer		Employer Address	
Prescribing Physician's Name			How did you hear about our office?		
			<input type="checkbox"/> M.D. <input type="checkbox"/> Friend <input type="checkbox"/> Family <input type="checkbox"/> Other:		

### INSURANCE / FINANCIAL INFORMATION PLEASE FILL OUT: INFORMATION NOT ON YOUR INSURANCE CARD

Type of Insurance		Subscriber's Name		Subscriber's Date of Birth	
Person Responsible for Bill or Parent's name			Responsible Party Address or Parent's address		
Phone Number		Student Status		Accident Status	
		Full-time / Part-time		None / Auto / Work	
				Date of injury	
				Athletic Injury	
				Claim Form: Yes / No	

### WORKERS' COMPENSATION ONLY

Workers' Compensation Claim # (If Applicable)		Claim's Adjuster		Adjuster's Phone Number	
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### IN CASE OF EMERGENCY

Contact Name		Relationship to Patient		Phone: Home		Work/Cell (Circle One)	
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### TELL US ABOUT YOUR CURRENT PROBLEM:

Onset (circle one): Gradual / Sudden      Onset Date: / /

How did it begin:

Previous Episodes?:      Yes / No      Number:

Symptoms:  
 Pain  
 Numbness/Tingling  
 Weakness/Instability  
 Stiffness  
 Other: \_\_\_\_\_

Fitness Activities:

Goals with PT:

Current Pain Level (how you feel today):

0	1	2	3	4	5	6	7	8	9	10
No Pain					Unbearable Pain					

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

