



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	
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	Date of injury	Athletic Injury	
	Full-time / Part-time	None / Auto / Work		Claim Form: Yes / No	

WORKERS' COMPENSATION ONLY

Workers' Compensation Claim # (If Applicable)	Claim's Adjuster	Adjuster's Phone Number
---	------------------	-------------------------

IN CASE OF EMERGENCY

Contact Name	Relationship to Patient	Phone: Home	Work/Cell (Circle One)
--------------	-------------------------	-------------	------------------------

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: _____

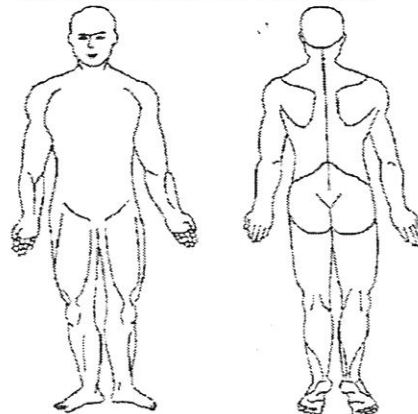
Fitness Activities:

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





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 answer all questions regarding you CURRENT problem:

Diagnostic Tests: [] None [] X-Ray [] MRI [] Other: Results:
Previous Treatments: [] PT [] Chiro [] Meds [] Exercise [] Other:

Activities, Movements, or Positions that INCREASE symptoms:

[] Sitting/Deskwork [] Standing [] Walking [] Overhead Reaching [] Lifting [] Bending/Twisting [] Sports
[] Lying Down [] Exercise [] Other:

Activities or Positions that DECREASE symptoms:

[] Rest [] Ice [] Heat [] Medications [] Movement [] Sitting [] Standing [] Lying Down [] Exercise [] Other:

HAVE YOU RECENTLY NOTICED?

Yes No Weight Loss/Gain Yes No Fatigue Yes No Chest Pain
Yes No Nausea/Vomiting Yes No Fever/Chills/Sweats

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

Yes No Allergies Yes No Depression Yes No Multiple Sclerosis
Yes No Anemia Yes No Diabetes Yes No Osteoporosis
Yes No Anxiety Yes No Dizzy Spells Yes No Parkinson's
Yes No Arthritis Yes No Emphysema/Bronchitis Yes No Rheumatoid Arthritis
Yes No Asthma Yes No Fractures Yes No Seizures
Yes No Cancer Yes No Gallbladder Problems Yes No Speech Problems
Yes No Cardiac Conditions Yes No Hepatitis Yes No Strokes
Yes No Cardiac Pacemaker Yes No High Blood Pressure Yes No Thyroid Disease
Yes No Chemical Dependency Yes No Incontinence Yes No Tuberculosis
Yes No Circulation Problems Yes No Kidney Problems Yes No Vision Problems
Yes No Currently Pregnant Yes No Metal Implants Other:

LIST ALL SURGERIES AND/OR INJURIES FOR WHICH YOU HAVE BEEN TREATED

Month/Year: Month/Year:
Month/Year: Month/Year:
Month/Year: Month/Year:

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING FOR ANY CONDITION:

Dosage: Reason: Dosage: Reason:
Dosage: Reason: Dosage: Reason:
Dosage: Reason: Dosage: Reason:

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 carrier. I understand that my insurance carrier Explanation of Benefits is the final determination of payment and patient responsibility regardless of benefit quotes prior to treatment.

X
PATIENT/GUARDIAN SIGNATURE DATE

HIPPA Privacy Practices Acknowledgement

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

Name Birthdate

Signature Date