IPA PHYSIO DALLAS
469.782.9978
dallas@ipa.physio
WWW.IPA.PHYSIO

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ (MM / DD / YYYY) | Select One: ☐ MALE ☐ FEMALE

Marital Status: ☐ SINGLE ☐ MARRIED ☐ OTHER | ☐ NOT LISTED (*please specify*): _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (*if different from Home Address*): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Desired primary form of contact: ☐ EMAIL ☐ HOME # ☐ CELL # ☐ WORK #

Emergency Contact/Legal Guardian: _____

Relationship to Patient: _____ Contact Phone Number: _____

Who referred you to IPA Physio: _____

Name of Primary Care or Referring Physician: _____

Contact information for Primary Care or Referring Physician: _____

_____

INSURANCE INFORMATION

Insurance Company: _____

Group Number: _____ Policy/ID: _____

Planholders Name (*If not Patient*): _____

Planholders DOB: _____ (MM / DD / YYYY)

Relationship to Patient: _____

Planholders Home Address: _____

Planholders City: _____ State: _____ Zip: _____

It is the patient's or guardian's responsibility to inform IPA Physio of any changes to your insurance coverage or carrier

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Reason for visit: ☐ INJURY ☐ ACCIDENT ☐ SURGERY

Describe your current injury(ies): _____

_____

When did your pain start? _____

What do you think caused your pain? Why? _____

_____

Since its initiation, have your symptoms:

☐ BECOME WORSE ☐ BECOME BETTER ☐ REMAINED THE SAME

What increases your pain? _____

What eases your symptoms? _____

Describe any relevant previous injuries: _____

_____

_____

List any other relevant medical history (*i.e. conditions or surgeries*) that your therapist should be aware of (*please also fill out next page*): _____

_____

_____

Have you undergone any diagnostic testing (i.e. MRI, X-Ray, Nerve Conduction, etc)? _____

_____

Are You Taking Any Medications? ☐ Yes ☐ No

If yes, please list medications and dosage: _____

_____

What are *YOUR* goals for treatment? (What would you do differently if you were not in pain?): _____

_____

_____

_____

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PAST MEDICAL HISTORY

Please answer the questions below to the best of your ability prior to having your initial visit with your physical therapist.

REVIEW OF SYSTEMS

Please mark the appropriate yes or no box (*Describe any "Yes" answer on the following page*):

YES:	NO:		
☐	☐	General	(*e.g. fever or chills, poor general health, unexplained weight loss, fatigue*)
☐	☐	Skin	(*e.g. rashes, new skin lesions, or a change in moles*)
☐	☐	Eyes	(*e.g. blurred vision, or change in visual acuity*)
☐	☐	Ears	(*e.g. ear pain or difficulty hearing*)
☐	☐	Nose	(*e.g. nasal congestion, discharge, or bleeding*)
☐	☐	Mouth/throat	(*e.g. sore throat, or difficulty swallowing*)
☐	☐	Respiratory	(*e.g. shortness of breath, cough, wheezing*)
☐	☐	Cardiovascular	(*e.g. nausea, high/low blood pressure, palpitations*)
☐	☐	Gastrointestinal	(*e.g. vomiting, diarrhea, constipation, abdominal pain, discolored stools*)
☐	☐	Irregular Bowel Movements	(*e.g. less than one per day*)
☐	☐	Genitourinary	(*e.g. problems initiating/controlling my bladder or urinary infrequency*)
☐	☐	Women's Health	(*e.g. pain with intercourse, painful menstrual cycle, etc.*)
☐	☐	Endocrine	(*e.g. heat or cold intolerance, weight loss or gain, increasing thirst*)
☐	☐	Hemato-immunologic	(*e.g. bruise easily, bleeding*)
☐	☐	Bone Health	(*e.g. osteoporosis, osteopenia, etc.*)
☐	☐	Psychiatric	(*e.g. depression, anxiety, suicidal thoughts or attempts*)
☐	☐	Smoking	(*e.g. occasional, daily, etc.*)

Fun fact about you or anything you want to share about yourself! _____

_____

_____

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Please detail any YES answers from the previous page: _____

_____

_____

_____

_____

_____

_____

_____

If your symptoms fit one of these two categories, please select the appropriate responses. Select the number that describes your symptoms TODAY:

(0 = No pain or Never there, 10 = Worst possible or Always there)

NECK / ARM

1. How bad is your neck/upper back pain?
   0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
2. How frequent is your neck/upper back pain?
   0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
3. How bad is your arm pain?
   0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
4. How frequent is your arm pain?
   0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
5. How bad is your numbness/tingling?
   0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
6. How frequent is your numbness/tingling?
   0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

LOWER BACK / LEG

1. How bad is your back pain?
   0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
2. How frequent is your back pain?
   0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
3. How bad is your leg pain?
   0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
4. How frequent is your leg pain?
   0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
5. How bad is your numbness/tingling?
   0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
6. How frequent is your numbness/tingling?
   0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

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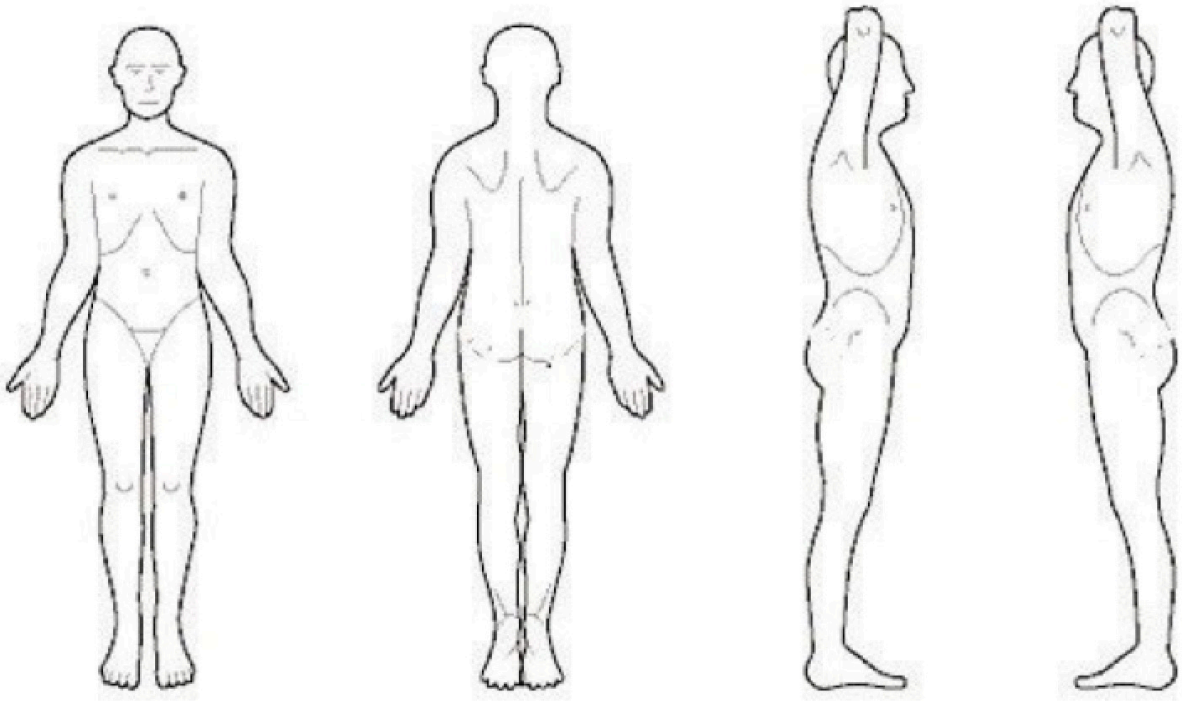
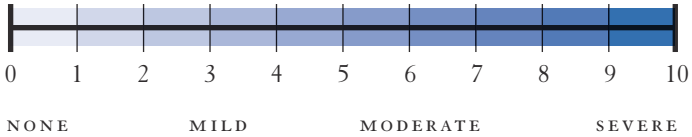
Draw on the figure below where you feel or have felt related pain and/or symptoms.

SYMPTOMS YOU FEEL TODAY: *Use "X" marks*

SYMPTOMS PRIOR TO TODAY: *Use "O" marks*



Please indicate the intensity of current, best, and worst pain levels over the past 24 hours on a scale of 0 (no pain) to 10 (worst pain imaginable)"



Current ____ / 10 Best in past 24 hours ____ / 10 Worst in past 24 hours ____ / 10

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ADVANCED PHYSICAL THERAPY SERVICES

IPA Physio is made up of a group of dedicated and compassionate manual physical therapists whose goal is to improve the lives of our patients using thorough evaluation and treatment techniques. The emphasis of care is Functional Manual Therapy, which includes Functional Mobilization™, soft tissue and joint mobilization, posture and movement training, and individualized exercise programs.

WHAT TO EXPECT ON FIRST VISIT

Your initial evaluation will be completed in 1 hour and treatment may begin on the first visit if time permits. You should wear comfortable clothing that can easily expose the injured joint or body part. Our therapists can perform the physical therapy evaluation and treatment without a doctor's prescription. If you have any X-rays, MRIs, or other medical documentation related to your injury, please bring these to the first appointment.

MISSION STATEMENT

To create a movement culture that facilitates thriving, challenges the norms, and optimizes the human experience by providing the highest quality methodical physical therapy.

IPA Physio's goal is to assist patients in their recovery from injury so they can return to a lifestyle that they can enjoy. We believe strongly in promoting overall wellness and injury prevention. We design customized treatment programs to meet each patient's specific needs, utilizing a Functional Manual Therapy™ Approach. Our Physical Therapists are committed to ongoing continuing education to ensure professional growth. All of our Therapists have obtained additional Functional Manual Therapy™ certifications and advanced professional training that require years of consistent dedication to obtain. We believe in ongoing mentorship and continued clinical research as a means to continuously improve our patient outcomes. It is this combination of clinical expertise, genuine caring, and a strong community reputation that sets IPA Physio apart.

Our therapists comply with privacy regulations set forth by HIPAA and will protect each patient's privacy without compromise.

IPA PHYSIO is an out of network provider of physical therapy. As a courtesy, we will submit claims to your insurance company to assist with reimbursement of out of network benefits. IPA PHYSIO cannot guarantee reimbursement. IPA PHYSIO is not a Medicare provider. We cannot submit to Medicare for our patients.

By signing below, I certify all information on this form is true and correct to the best of my knowledge.

Signature: _____ Date: _____