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PATIENT INFORMATION

Last Name: ______________ First Name: ______________ MI: ________

Date of Birth: __________ (MM / DD / YYYY) Marital Status: ☐ SINGLE ☐ MARRIED ☐ OTHER

Gender: ☐ MALE ☐ FEMALE ☐ OTHER (*please specify*): ______________

Preferred Pronouns: ☐ *he/him/his* ☐ *she/her/hers* ☐ *they/them/theirs* ☐ OTHER (*please specify*): ________

Sex Assigend at Birth: ☐ MALE ☐ FEMALE ☐ OTHER (*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 and 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?: ______________________________

____

____

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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.*)

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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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Adapted by Dean Hazama, PT, CFMT

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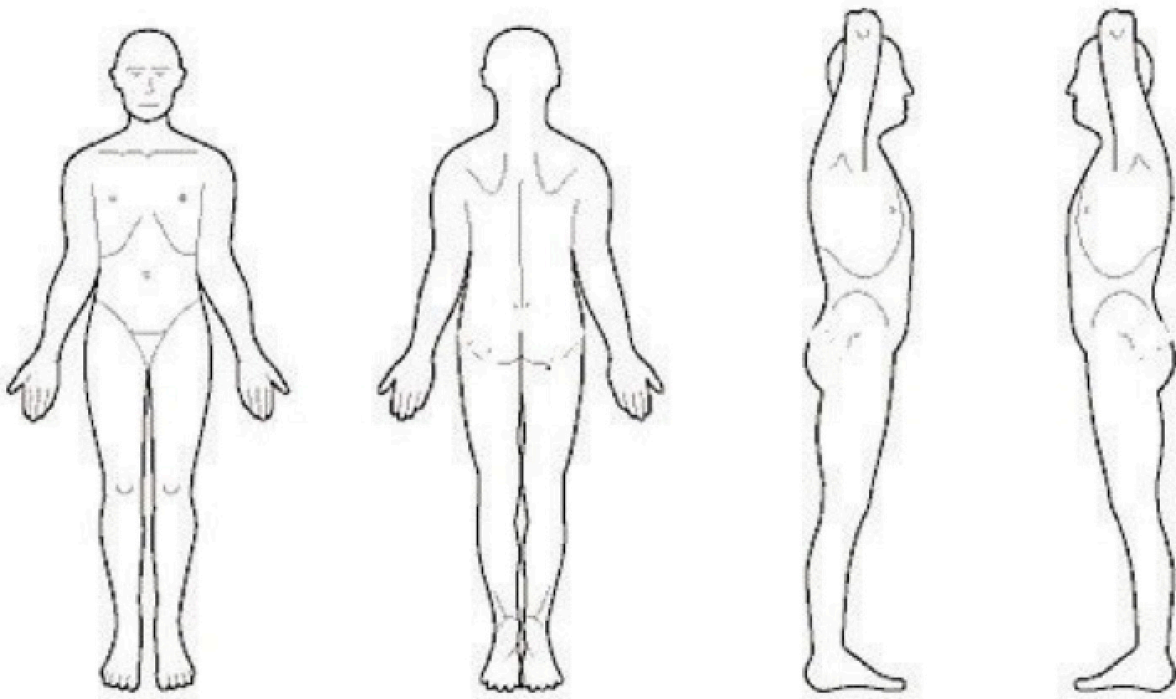
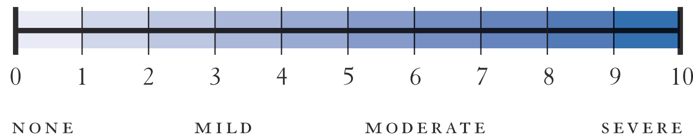
Draw on the figure below where you feel or have felt related pain and/or symptoms.

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: ______________

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