

OPTIMUM PHYSICAL THERAPY ASSOCIATES, P.C.

Glenn Venturini, PT MPT MS

Craig Fava, PT OCS COMT

Patient's Name: _____ Date _____
Last First MI

Address: _____
Street City State Zip Code

Phone w/area code _____ work phone _____ cell phone _____

Patient's Date of Birth _____ / _____ / _____

Sex: Female Male Marital Status: Married Single

Referring Physician (if any) _____

Location at which you see Referring Physician _____

Date of next visit with Referring Physician _____

Primary Physician _____ Phone Number _____

Would you like your notes sent to your primary physician? YES NO

Who should we contact in case of Emergency? _____ Phone _____

If you had an accident or work-related injury please complete the box below;

Date of Accident: _____	<input type="checkbox"/> Auto	<input type="checkbox"/> Work Related
Attorney's Name, if any _____	Phone _____	
Insurance Company: _____		
Address _____	Phone _____	
Claim Number _____	Adjuster _____	Name of Insured _____

Please provide a copy of your insurance card(s) and complete information below on the insured's name and date of birth if different from the patient's. (only include ID numbers if cards were not provided.)

Primary Insurance:	
Insured's Name _____	Birth Date _____
ID Number _____	Group Number _____
Secondary Insurance _____	
Insured's Name _____	Birth Date _____
ID Number _____	Group Number _____

Please tell us how you learned of our services or whom we may thank

- I was previously a patient
- Doctor Recommendation
- Insurance Company
- Yellow Pages Ad
- Webpage
- Former Patient Recommendation; Name _____
- Family or Friend Recommendation; Name _____
- Case Manager Recommendation
- Newspaper Ad
- Other, please specify _____

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To ensure you receive a complete and thorough evaluation, please provide us with the important background information requested on this form. If you do not understand a question, please leave it blank and your therapist will assist you. Thank you!

Name _____ Birth Date _____

Leisure Activities, Sports or Hobbies: _____

Employer: _____ Occupation _____

Allergies: Please list any medications you are allergic to: _____

Yes No Are you latex Sensitive?

Please list any other allergies we should know about _____

Please Check any of the following whose care you are under:

- Physician (MD, DO) Podiatrist (DPM) Psychiatrist/Psychologist Dentist
- Physical Therapist Chiropractor (DC) Other _____

If you have seen any of the above professionals during the last 3 months, please describe the reason (illness, medical, routine, etc) _____

Have you EVER been diagnosed as having any of the following conditions?

- Yes No Cancer
- Yes No Heart Problems
- Yes No High Blood Pressure
- Yes No Circulation Problems
- Yes No Asthma
- Yes No Emphysema/Bronchitis
- Yes No Chemical Dependency (alcohol/drug)
- Yes No Thyroid problems
- Yes No Diabetes
- Yes No Multiple sclerosis
- Yes No Rheumatoid Condition
- Yes No Other Arthritic Condition
- Yes No Depression
- Yes No Hepatitis
- Yes No Tuberculosis
- Yes No Stroke
- Yes No Kidney Disease
- Yes No Anemia
- Yes No Osteoporosis/Osteopenia



- Yes No During the Past Month have you been feeling down, depressed or hopeless?
- Yes No During the Past Month have you been bothered by having little interest or pleasure in doing things?
- Yes No Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way?
- Yes No FOR WOMEN: Are you currently pregnant or do you think you might be pregnant?

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Please List any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization.

Date	Reason for Surgery/Hospitalization

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate injury date.

Date	Injury	Date	Injury

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

- | | | | | | | | | |
|------------------------------|-----------------------------|----------|------------------------------|-----------------------------|---------------------|------------------------------|-----------------------------|----------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Arthritis |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mental Illness |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy |

Which of the following OVER THE COUNTER medications have you taken in the last week?

- | | | |
|------------------------------|-----------------------------|-------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Aspirin |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tylenol |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Advil/Motrin/Ibuprofen |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Laxatives |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Decongestants |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Antihistamines |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Antacid |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vitamins/Minerals/Supplements |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other _____ |

Office Use

Please List any PERSCRIPTION MEDICATIONS you are currently taking (pills, injections, skin patches)

How many caffeine-containing beverages do you drink per day? _____
 How many packs of cigarettes do you smoke per day? _____
 How many days per week do you drink alcohol? _____
 If one drink equals one beer or glass of wine, how much do you during at an average sitting? _____

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Have you recently noticed?

Office Use

- Yes No Weight loss/gain
- Yes No Nausea/Vomiting
- Yes No Dizziness/Lightheadedness
- Yes No Fatigue
- Yes No Weakness
- Yes No Fever/Chills/Sweats
- Yes No Numbness or Tingling

We need a date of onset of injury for billing your insurance. Please provide the date of onset of current condition with month/ day/year. _____/_____/_____

Briefly state how your injury occurred; _____

Please place one "X" on each line below to indicate the intensity of your pain or other symptoms.

EXAMPLE

(No Pain) _____ X _____ (Worst Pain Ever)

Current Pain; mark line to indicate your pain level at present time (as you complete this form).
(No Pain) _____ (Worst Pain Ever)

Least Pain; mark line to indicate the least amount of pain you have had in the last week.
(No Pain) _____ (Worst Pain Ever)

Worst Pain; mark line to indicate the highest level of pain you have had in the last week.
(No Pain) _____ (Worst Pain Ever)