Welcome To Our Practice

Patient Information:

Today's Date: _______________ Date of Birth: __________________ Sex: Male or Female

Name: (Last) _____________________________ (First) _________________________ (MI) ___________________

Mailing Address: ____

Home Phone: ____________________ Work Phone: ___________________ Cell Phone: _____________________

Email Address (For communication purpose only): ____

Bill my Insurance Company? ❑ No ❑ Yes (If yes, please fill out the Insurance information sheet.)

Emergency Contact? Name: ___________________________________ Home #: _________________________

Cell #: ___________________________ Relationship: ____

Primary and Referring Doctor Information:

Primary Care Doctor Name: ______________________________ Phone Number: ______________________________

Referring Doctor Name: ___________________________________ Phone Number: _________________________

Referral Source*:*

How did you hear about our clinic (please list)?

❑ Doctor Referred ❑ Internet Search ___________ ❑Other People: ____

❑ Seminar _______________ ❑Advertisement/Other ____

PATIENT CONSENT

Authorization for treatment

I hereby request and agree to be treated by ARC Physical Therapy & Pain Center.

Authorization for insurance billing and collection

I hereby authorize ARC Physical Therapy & Pain Center to bill my insurance, including releasing information requested by the insurance company and other procedures necessary to collect the claims on my behalf.

______________________________________ ___________________

Patient Signature Date

Patient Privacy (HIPPA): ARC follows the Federal guidelines to protect your privacy. **NO** information will be released to any third party unless specified by you. Please **initial** here to acknowledge: __________.

Information Release: ❑N/A or ❑If you wish to release information to any party, please specify here:

I, _________________________ (print name), hereby authorize ARC to release my information to

____.

Signature: ____Date: __________________________

(ARC-HIPPA patient privacy policy is available upon request.)

**Any future request to release information must be in writing addressed to ARC.

Personal History *(Check all applicable*):

❑Rheumatic fever ❑Pneumonia ❑Anemia ❑Gallbladder Disease ❑Epilepsy ❑Bladder Disease ❑Diabetes
❑Kidney problem ❑Food/Drug Allergy ❑TB ❑Sinus problem ❑Asthma ❑Heart Disease ❑Pacemaker ❑AIDS
❑Electronic Implanted Device ❑Hepatitis A/B/C/D ❑Alcohol/Substance Abuse ❑High Blood Pressure ❑Ulcers
❑Digestive Disorders ❑High Cholesterol ❑Depression ❑Anxiety ❑Bipolar Disorder ❑Concussion or Head Injury
❑Auto-immune Disorders, such as Lupus, Rheumatoid arthritis, MS ❑Loss of Consciousness ❑Thyroid problem

ARC Physical Therapy & Pain Center

PATIENT HISTORY

Date:______________ Name:_____________________________________

CHIEF complaint (the reason for visiting us today):____________________
____
____

Is this: ❑ Chronic w/ acute flare up (how chronic?)________or ❑ Sudden onset

When did the current condition / pain start? ______________________

What caused the condition / pain?______________________________
____

Is it due to an accident? ❑ No ❑ Yes, List date of accident: ___________

What kind: ❑ Fall ❑ Auto ❑ Work ❑ Home ❑ Other:_________________

Do you have ❑ X-Ray ❑ MRI ❑ CT-Scan ❑ others _______, Can you get the film or report? ❑ Yes, ❑ No

Are you using: ❑Cane ❑Walker ❑Other assistive device: _______________

Your Goal: ❑Symptom relief only ❑Elimination of Root Cause ❑Stop/prevent further degeneration ❑Whatever help I can get

Pain Tolerance: ❑Very low ❑Low ❑Moderate ❑High❑ Very high

Note: (official use only)

If you are in pain, please **MARK** the exact location of your pain on the figure. Please describe:

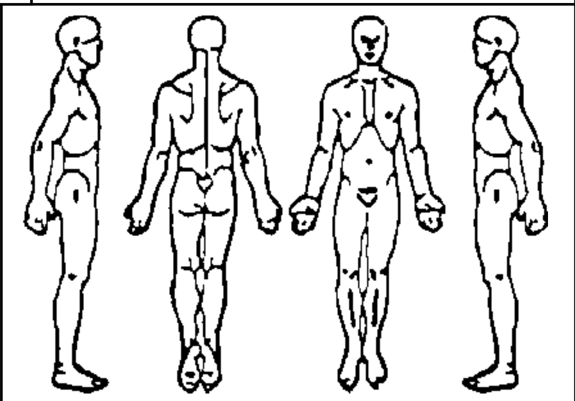
Type of pain: ❑Sharp ❑Dull aching ❑Shooting ❑Numb ❑Pins & Needles ❑Nagging ❑Burning ❑Stabbing ❑Throbbing ❑Cramping ❑Other_______

Frequency: ❑Constant ❑Motion triggered ❑Intermittent

How severe is your current condition? ❑Mild ❑Moderate ❑Severe.

Pain scale from 1 to 10 (10 being the greatest), where is your pain? (without pain med)______/10, (with pain med) _____/10.

Condition worsen @ ❑First wake up ❑With more activity ❑During sleep ❑When tired ❑Sit or stand too long ❑At the beginning of movement



What makes your condition worse?____

What makes your condition better? ____

Does your condition interferes with: ❑Work ❑Daily routine ❑Sleep ❑other:_____________________

Have you received prior treatment for this condition? ❑ Yes ❑ No.

If yes, Where / by whom?______________________ What was the diagnosis?_________________

What were the treatment results?____
____

Please list all medications you are currently using:_____________________________________
____
____

Please list all surgeries by type and year:____
____

Success Criteria: (Please describe the improvement you expect; so our intervention will be considered as successful?)
____
____