Hands On
Physical Therapy

Name: _____ Home Phone: _____
Street: _____ Work Phone: _____
City: _____ State: ____ Zip: _____ Cell Phone: _____

Birth Date: _____ / _____ / _____ Age: _____ Social Security #: _____ - _____ - _____

Email address: _____
Referring Doctor: _____
Doctors that you currently are seeing: _____
How did you hear about us? _____

• Please list any other medical conditions you have ever had (heart, lung, kidney, liver, gall bladder, ovaries, uterus, stomach, intestines, prostate, thyroid, pancreas, musculoskeletal, or anything else not listed):

_____
_____
_____

• Please list any surgeries that you have ever had in your life: _____
_____

• Please list any medications, herbals, and nutritional supplements that you are currently taking (Please include dosage, frequency, and route of administration (ie. By mouth):

_____
_____
_____
_____
_____
_____

Visual Analog Pain Scale: Please indicate with a mark where your pain level is:

1---------2---------3---------4---------5---------6---------7---------8---------9---------10

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government or private benefits to myself or to the party who accepts assignments on this claim.

Signature: _____ Date: _____

Hands On
Physical Therapy

Place a **V** in front of each item that you experience at least monthly.
Place an **X** in front of each item that you experience weekly or more frequently.

_____ Blushing, flushing face
_____ Can't keep warm enough
_____ Chest pain, tightness
_____ Headaches
_____ Heart pounding or racing
_____ Irregular heartbeat
_____ Numbness, tingling in arm or leg
_____ Sweaty palms

_____ Asthma or shortness of breath
_____ Common colds
_____ Coughing
_____ Earache or ringing noise in ears
_____ Hay fever or allergies
_____ Sore throat
_____ Stuffy nose, congestion

_____ Back problems
_____ Dry mouth
_____ Excessive perspiration
_____ Eyes irritated or inflamed
_____ Eyestrain or discomfort
_____ Grinding of teeth (TMJ)
_____ Mouth Sores
_____ Nosebleeds
_____ Skin rashes, eruptions
_____ Sore, aching muscles
_____ Stiff or tender joints
_____ Trembling / twitching muscles
_____ Vision blurred

_____ Awaken too early in the morning
_____ Difficulty falling asleep
_____ Difficulty sleeping through the night
_____ Excessive drowsiness throughout the day
_____ Feeling faint or dizzy
_____ Periods of extreme fatigue

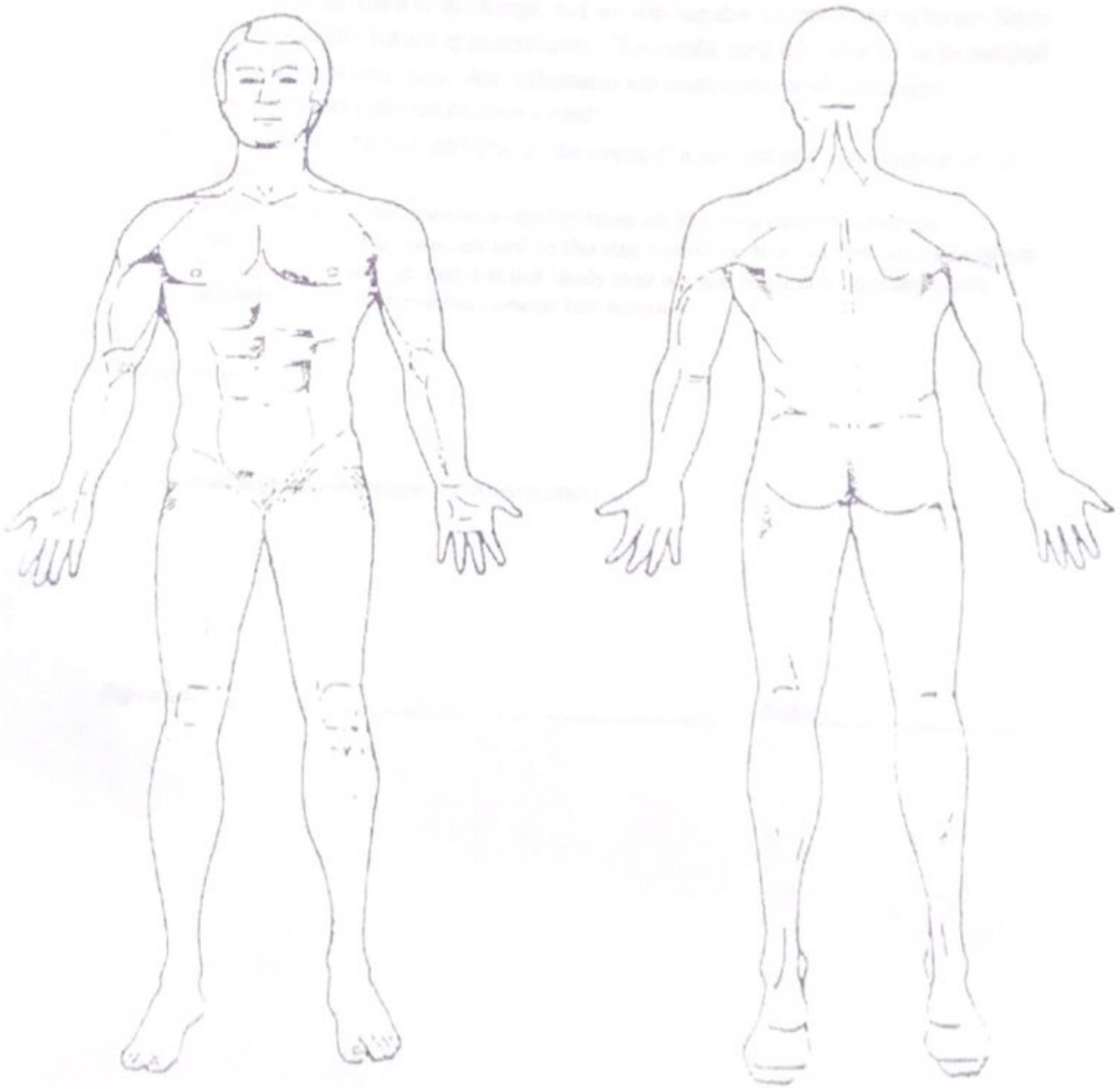
_____ Difficulties with family or friends
_____ Easily annoyed or irritated
_____ Excessive alcohol abuse
_____ Fearful of persons or places
_____ Feeling inadequate / unable to cope
_____ Feeling tense or nervous
_____ Feelings of guilt or failure
_____ Free-floating anxiety about life
_____ Frequent laxative use
_____ Lack of appetite
_____ Other substance abuse
_____ Over-eating, bingeing
_____ Recurring bad thoughts
_____ Suicidal thoughts
_____ Uncontrolled crying or sadness
_____ Voice quivering, shaking
_____ Worrisome thoughts

_____ Bowel irregularity
_____ Bowel leakage
_____ Constipation
_____ Diarrhea
_____ Frequent urination
_____ Gas in lower bowel
_____ Heartburn / indigestion
_____ Incomplete urination
_____ Nausea or vomiting
_____ Painful urination
_____ Stomach cramps
_____ Urinary leakage

_____ Breast tenderness
_____ Hot flashes
_____ Menstrual difficulties
_____ Pre-menstrual Syndrome
_____ Unable to enjoy sex
_____ Unable to participate in sex acts
_____ Uninterested in sex
_____ Water retention

Hands On
Physical Therapy

Shade all areas of pain on the diagram below.
Please include areas other than those you are here for today.



Hands On
Physical Therapy

Hands On Physical Therapy Late Cancellation/ No Show Policy

If we do not receive 24 hours notice for canceling an appointment:

- The first time there is no charge, but we will require a credit card to be on file in order to secure future appointments. This credit card will need to be presented at the time of your next visit, otherwise we must remove all scheduled appointments until we receive a card.
- Your card will be charged $50 in the event of a second late cancellation or no show
- If you prefer to not give us a card to keep on file, you cannot schedule appointments, but you can call us the day before or the day that you would like to come in to see us, but it is not likely that we will have any appointments available, unless someone cancels last minute.

Thank You

I have read and acknowledge this information.

Signature:_____ Date:_____