Client Medical History

Name: _____ Today's date: _____
Referring physician: _____ Date of injury or onset: _____
Date of 1st doctor visit for this injury: _____ Date of next doctor's visit: _____
Is an attorney involved in this case? ❑ Yes ❑ No

Have you had any of the following medical or rehab services of this injury/episode? Please check if "yes":

❑ General practitioner
❑ Chiropractic
❑ Massage therapy
❑ Occupation therapy
❑ Physical therapy
❑ Other: _____
❑ ER care
❑ Neurologist
❑ Orthopedist
❑ Podiatrist
❑ Acupuncture
❑ X-rays
❑ CT scan
❑ MRI
❑ EMG/NCV
❑ Myelogram

Are you currently taking any prescription or non-prescription medication? ❑ Yes ❑ No
❑ Pain medication ❑ Anti-inflammatory ❑ Muscle relaxant
Please list: _____

Do you have a pacemaker? ❑ Yes ❑ No
Are you pregnant? ❑ Yes ❑ No
Severe allergies (i.e. latex, oils, perfumes, peanuts, etc.) _____
Do you currently have cancer, or have you had cancer within the past 5 years? ❑ Yes ❑ No
Have you had any falls in the last year? ❑ Yes ❑ No **If yes, how many?** _____

Do you now have, or have you ever had, any of the following? Please check if "yes":

❑ Shortness of breath
❑ Heart disease or angina (chest pain)
❑ Heart attack or cardiac surgery
❑ Congestive heart disease
❑ High blood pressure
❑ Stroke or TIA
❑ Blood clot or embolism
❑ Epilepsy or other seizures
❑ Thyroid disease or goiter
❑ Anemia
❑ Infectious disease
❑ Diabetes
❑ Chemotherapy and/or radiation
❑ Arthritis
❑ Osteoporosis
❑ Gout
❑ Sleeping difficulty
❑ Pain at night or night sweats
❑ Emotional or psychological concerns
❑ Asthma, bronchitis, or emphysema
❑ Vision or hearing problems
❑ Numbness or tingling
❑ Dizziness or fainting
❑ Bowel or bladder problems
❑ Weakness
❑ Recent, unexplained weight loss or energy loss
❑ Hernia
❑ Varicose veins
❑ Severe or frequent headaches
❑ Pins or metal implants
❑ Joint replacement surgery
❑ Neck injury or surgery
❑ Shoulder injury or surgery
❑ Elbow/hand injury or surgery
❑ Back injury or surgery
❑ Knee injury or surgery
❑ Leg/ankle/foot injury or surgery
❑ Other injury or surgery _____

Do you use: ❑ tobacco ❑ alcohol ❑ marijuana (medical or otherwise) ❑ other or illicit drugs

(Please continue on the other side)

Physical Therapy Initial Evaluation

Pre-exam Questionnaire

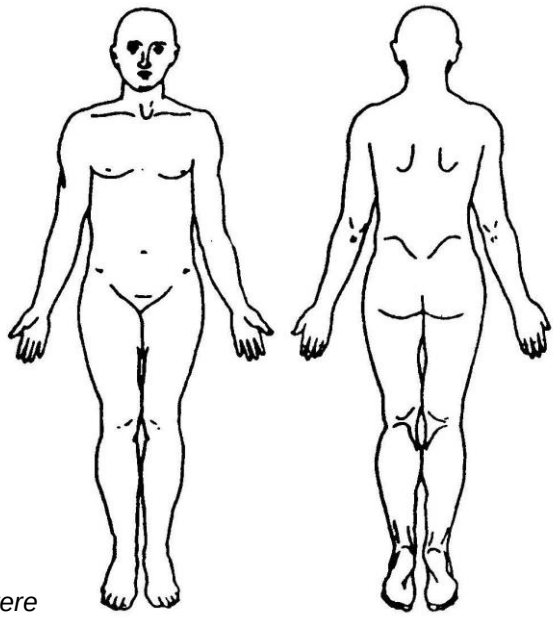
1. Check ALL that apply to your current symptoms:

❑ Work related injury ❑ Injury related to lifting
❑ Motor vehicle accident ❑ Injury related to falling
❑ Athletic or recreational injury ❑ Chronic or long term issue
❑ Recurrence of previous injury ❑ Cause unknown
❑ Other _____

2. Are you presently working?

❑ Working full duty ❑ Working modified or light duty ❑ I am not working
If working, date returned to work: _____
If not working, last date worked due to injury: _____
What is your occupation? _____

3. What is the location of your current pain or problem?
Please mark the picture at right with an "X" where you feel pain. →



4. Have you ever had this pain or problem before? ❑ Yes ❑ No

5. Is your pain or problem…?

❑ getting worse ❑ getting better ❑ staying the same

6. Is your pain or problem…?

❑ constant ❑ frequent ❑ occasional ❑ infrequent

7. On the scale below, please circle your worst pain level in the past few days:

mild *moderate* *severe*

0…….1…….2…….3…….4…….5…….6…….7…….8…….9…….10

8. Are you taking medication for this problem? ❑ Yes ❑ No
If yes, please specify: _____

9. Are any of your usual activities affected? ❑ Yes ❑ No
If yes, please specify: _____

10. Are you aware of your diagnosis & prognosis as explained by your doctor? ❑ Yes ❑ No

11. Based on you awareness, what are your rehabilitation expectations and goals while in physical therapy?

_____
_____

The above information is accurate to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____

Oasis Physical Therapy – Patient Registration Form

Patient Demographic Information

Last Name: _____ First Name: _____ Middle Initial: _____

SSN: _____ Home Ph: _____ Cell Ph: _____Cell Ph. Carrier:_____

Address: _____ City: _____ State: _____ Zip: _____

Gender: Male / Female Date of Birth:_____ Email Address: _____

Emergency Contact: _____ Phone: _____ Status: Single/Married/Widowed

Employment Information

Employer Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Work Injury / Motor Vehicle Accident

Claim Manager: _____ Claim Manager Phone: _____

Are you represented by an Attorney Yes / No Attorney Name & Phone: _____

○ Work Related Injury: Yes / No Date of Injury: _____ Claim #: _____ State: ___

○ Motor Vehicle Accident: Yes / No Date of Accident:_____ Claim #: _____ State: ___

Commercial Insurance

Primary Insurance: _____ ID/Policy #: _____ Group #: _____

Subscriber Name:_____ Social Security #: _____ DOB: _____

Secondary Insurance: _____ ID/Policy #: _____ Group #: _____

Subscriber Name:_____ Social Security #: _____ DOB: _____

Responsible Party Information (Required if Patient is a Minor)

Last Name: _____ First Name: _____Middle Initial: _____

SSN: _____ Date of Birth:_____ Gender: Male / Female

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: _____ Cell Ph: _____ Relationship to Patient: Self / Spouse / Child / Other

---

I authorize Oasis Physical Therapy to render physical therapy services to myself or person to whom I am legal guardian. I understand I am financially responsible for any balance. I also authorize Oasis Physical Therapy or my insurance company to release any information required to process my claims. I authorize Oasis Physical Therapy or any collection company to contact me by my cellular telephone for billing activities or payment arrangements. I have read and understand all of the above information. The information provided is true and correct to the best of my knowledge.

Signed for myself and dependents: _____**Date:** _____

Oasis Physical Therapy - Notification of Policies

Acknowledgment or Receipt of Privacy Practices

I have received a copy of Oasis Physical Therapy's notice of Privacy Practices. I understand that I have the right to refuse to sign the acknowledgment if I so choose.

Oasis Physical Therapy is allowed to discuss all aspects of my care with:

Contact Name:_____
Contact Name:_____
Contact Name:_____

Initial_____

Assignment and instructions for direct payment to Oasis Physical Therapy

I hereby instruct _____ insurance company to pay by check to: **Oasis Physical Therapy at 6825 Burden Blvd, Ste D, Pasco, WA 99301.** If my policy prohibits direct payment to provider, then I hereby instruct and direct you to make out the check to me and mail it to the address above. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to Oasis Physical Therapy, and I have agreed to pay any balance of said professional charges over and above the insurance payment. I also authorize any release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

No Show & Cancellation Policy

Failure to cancel 24 hours prior to your appointment time or not showing for your appointment will result in a **$20.00 fee**. Your insurance **will not** cover this charge. For worker's compensation claims, missed appointments may be forwarded to your case manager and your primary physician.

Initial_____

Oasis Commitment to Patient

Oasis Physical Therapy is a privately owned, outpatient, orthopedic physical therapy clinic. When you become a client of Oasis Physical Therapy, you do not hire just one person. You employ a team of professionals who work together to help you meet your goals. As manually trained therapists, one of those tools, are our hands. Through our hands we evaluate musculoskeletal imbalances contributing to your dysfunction. Following evaluation, we then begin effectively implementing a treatment program through soft tissue and joint mobilization techniques to improve your ability to move. Our goal is to help you eventually regain maximal pain free motion in postural alignment during functional activities.

At Oasis Physical Therapy we employ both male and female therapists as part of your rehab team. It is important to us that you are always comfortable with the manual portion of your treatment. To assist with your comfort we provide gowns, tank tops, shorts and towels for draping to ensure modesty for the patient while we provide quality manual care. If at any time you still feel uncomfortable, we strongly urge you to please feel free to let us know. We will customize your schedule as needed to ensure your comfort, and therefore the best therapeutic environment to meet your goals.

We are honored that you chose us to help you with your rehabilitation. By doing so, you have joined a dedicated team of professionals whose focus is on you. Your success is our success.

Initial_____