



Confidential Medical History

Name: _____ Date of Birth ____/____/____ SS#: _____

Address: _____ City/State/Zip: _____

Phone: _____ Cell: _____ Marital Status (Circle): M S D W

Occupation: _____ Are you presently working? Y__ N__

Employer: _____ Employer Phone: _____

Insurance Company: _____ ID#: _____

Name of Card Holder: _____ Date of Birth ____/____/____ SS#: _____

Have you received any of the following services during your current insurance plan year?

Occupational Therapy	Y__ N__	Massage Therapy	Y__ N__
Physical Therapy	Y__ N__	Chiropractic Services	Y__ N__
Speech Therapy	Y__ N__	Home Health Services	Y__ N__

Do you have any of the following medical conditions?

	YES	NO		YES	NO
Asthma, Bronchitis or Emphysema	_____	_____	Osteoporosis	_____	_____
Shortness of Breath or Chest Pain	_____	_____	Diabetes	_____	_____
Coronary Heart Disease	_____	_____	Bowel or Bladder Problems	_____	_____
Pacemaker	_____	_____	Sleeping Difficulties	_____	_____
High Blood Pressure	_____	_____	Emotional or Psychological Problems	_____	_____
Heart Attack or Surgery	_____	_____	Severe or Frequent Headaches	_____	_____
Stroke or TIA	_____	_____	Vision or Hearing Difficulties	_____	_____
Blood Clot or Emboli	_____	_____	Dizziness or Faintness	_____	_____
Epilepsy or Seizures	_____	_____	Pregnancy	_____	_____
Thyroid Trouble or Goiter	_____	_____	Arthritis or Swollen Joints	_____	_____
Cancer or Chemotherapy/Radiation	_____	_____	Gout	_____	_____
Infectious Diseases	_____	_____			
Other Medical Conditions: _____					

Referring Physician: _____ Referral Date: _____

Chief Complaint: _____ Date of Injury: _____

Current Symptoms: Pain Numbness Stiffness Weakness Other: _____

List all medications you are currently taking: None _____

List any known allergies: None _____

List any previous surgeries: None _____

Have you had any diagnostic imaging for this injury? None MRI XRAYS CT SCAN Other: _____

Do you smoke? Y__ N__ How much/often? _____

Do you consume alcohol? Y__ N__ How much/often? _____

Do you exercise regularly? Y__ N__ How much/often? _____

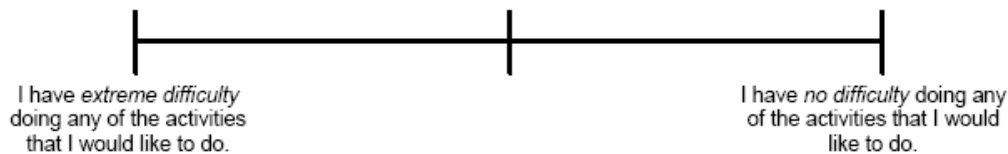


Patient Name: _____ Date: _____

Functional Assessment (OPTIMAL)

Instructions: Please circle the level of difficulty you have for each activity today.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving—lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking—short distance	1	2	3	4	5	9
10. Walking—long distance	1	2	3	4	5	9
11. Walking—outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking about all of the activities you would like to do, please mark an “X” at the point on the line that best describes your overall level of difficulty with these activities today.



23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: 1. 12 2. 8 3. 13)

1. ____ 2. ____ 3. ____

Present Total Score = _____ Previous Total Score = _____



Consent For Treatment

I hereby give my consent for medical treatment of my physical condition. I authorize the release of any medical information needed to process my claim. I understand that I am responsible to inform the office of any changes that occur with regard to my insurance policy. If I choose to file a claim through my insurance, I authorize release of payment directly to Advance Physical Therapy Specialists (doing business as Apex Chiropractic and Physical Therapy) regardless of whether benefits are deemed to be in-network or out-of-network. Should I default on my financial responsibility and monetary collection is necessary, I will be responsible for collection costs that are incurred.

Patient/Parent/Guardian Signature: _____ Date: _____

Receipt of Policies

I acknowledge that I have received the packet of patient policies which includes the following: HIPAA Notice of Privacy Practices, Attendance Policy, Financial Policy, and Financial Responsibilities. I understand that I may ask questions about these policies at any time.

Patient/Parent/Guardian Signature: _____ Date: _____

Telephone Contact Information

1) Please indicate any family members we may speak with regarding your care including but not limited to diagnosis, treatment plan, or prognosis.

_____	_____
_____	_____

2) May we leave a message on your answering machine? Yes No

Child/Adolescent Protection Policy (For patients under 18 years of age)

It is the policy of Apex Chiropractic and Physical Therapy to release minors only to the care of the following individuals following completion of their physical therapy visit.

_____	_____
_____	_____

Patient/Parent/Guardian Signature: _____ Date: _____