

Bluegrass Doctors of Physical Therapy, PLLC

Patient Contact Information

Today's Date _____

Patient Name _____
DOB _____
Address _____
City _____ State _____ ZipCode _____
Gender _____ Marital Status _____
Occupation _____
Home Phone _____ Cell Phone _____
Which number to do prefer to be contact at:
 Home Cell
 Work

Email _____
Employer _____
Work Phone _____
Work Address _____
City _____ State _____ ZipCode _____

Parent/Guardian/Spouse/Partner (Must complete if patient is under 18 years.)

Name _____
Address _____
City _____ State _____ ZipCode _____
Home Phone _____ Cell Phone _____

Emergency Information/ Nearest Relative

Same as above

Name _____ Relationship _____
Address _____ City _____ State _____
Zip Code _____
Home Phone _____ Cell Phone _____
Work Phone _____
 Medical information can be shared with this person.

Physician Information

Name _____
Address _____ City _____ State _____
Zip Code _____
Phone Number _____

I/We authorize *Bluegrass Doctors of Physical Therapy, PLLC* to release all medical information and/or records to my requesting insurance company and/or Referring physician (if referred from a physician).

Patient Signature

Date

Bluegrass Doctors of Physical Therapy, PLLC

Patient Questionnaire

Date _____

Name _____

From whom did you hear about us? _____

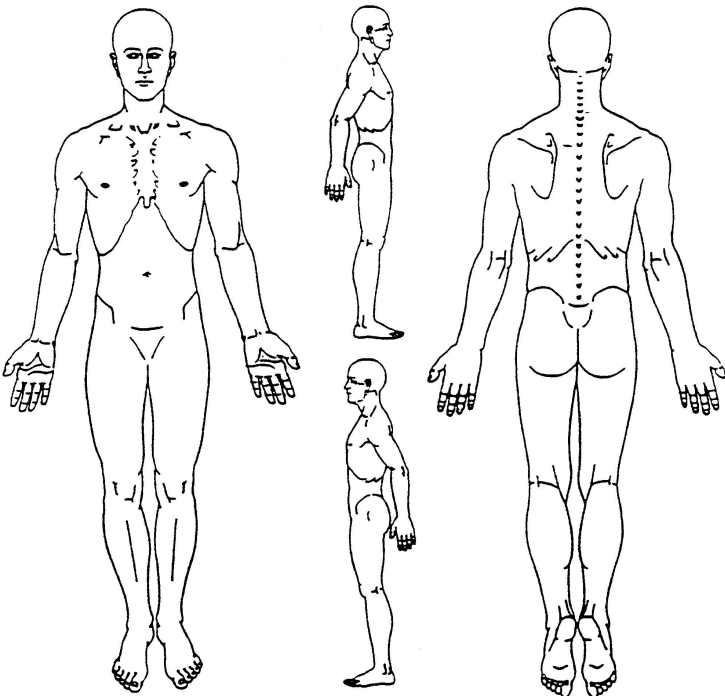
Are you currently pursuing or contemplating litigation for your condition for which you are seeking treatment (e.g. lawsuit, disability or workman's compensation). Yes _____ No _____ Not sure _____

History of current condition: (Please describe location, intensity, duration, and onset of condition. Use back of form if needed.)

Any special tests that have been performed, the body part tested, and the results. (ie: X-ray, MRI, CT Scan)

Have you had any other treatments for your current condition? (ie: PT, Chiropractic, Massage, Acupuncture) Please list practitioners.

Please indicate the areas you are having pain.
You may shade, color or simply mark the areas.



Please rate the intensity of your pain at its worse below:

0-1-2-3-4-5-6-7-8-9-10
(no pain) (Worst Imaginable)

What has made your pain worse?

Please rate the intensity of your pain at its best below:

0-1-2-3-4-5-6-7-8-9-10
(no pain) (Worst Imaginable)

What has made your pain better?

Bluegrass Doctors of Physical Therapy, PLLC

Name _____

Have you been advised to have any surgery that has not been done? When and what?

Please list all previous injuries, accidents, surgeries and any other pertinent medical information.
(Please include dates and type of surgery.)

Please list **all** medical conditions and/or health concerns.

Please list **all** current medications.

Please list **all** allergies including any latex, gels creams, adhesives or nickel allergies.

Do you currently have any metal, plastics or implants anywhere in your body?

Do you now have or have you had any of these symptoms in the past year? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Change in bowel movements | <input type="checkbox"/> Tiredness/fatigue |
| <input type="checkbox"/> Persistent joint pain | <input type="checkbox"/> Muscle spasms |
| <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Fainting spells |
| <input type="checkbox"/> Blood in bowel/urine | <input type="checkbox"/> Eating disorder/difficulty eating |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Difficulty Sleeping |
| <input type="checkbox"/> Vertigo or dizziness | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Persistent nose bleeds | <input type="checkbox"/> Osteoporosis/Osteopenia |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Learning disabilities | |

Bluegrass Doctors of Physical Therapy, PLLC

Name _____

Any history of: (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Dislocations or loose joints | <input type="checkbox"/> Bladder infection |
| <input type="checkbox"/> Head or spinal injuries | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Recurrent headaches: | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> How often _____ | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Knocked unconscious: _____ | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Meningitis | |
| <input type="checkbox"/> Stomach ulcers | |
| <input type="checkbox"/> Heartburn/indigestion | |
| <input type="checkbox"/> Shortness of breath | |
| <input type="checkbox"/> Smoking/Tobacco products: How much? _____ | |
| <input type="checkbox"/> Cancer? If so what kind? _____ | |
| <input type="checkbox"/> Other _____ | |

DENTAL/FACIAL HISTORY: (Only for patients with headaches and TMJ)

Who is your dentist? _____

Please check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Braces: If so, When: _____ | <input type="checkbox"/> TMJ Pain/Dysfunction |
| <input type="checkbox"/> Night Splint/Retainer | <input type="checkbox"/> Popping or clicking in jaw |
| <input type="checkbox"/> Grind or clench teeth | <input type="checkbox"/> Jaw locked |
| <input type="checkbox"/> Recurrent Sinus Infection | <input type="checkbox"/> Recurrent Ear Infections |

FOR WOMEN ONLY:

Please check if you have had a history of:

- | | |
|---|--|
| <input type="checkbox"/> Interstitial cystitis | <input type="checkbox"/> Cramping |
| <input type="checkbox"/> Pelvic inflammatory disease | <input type="checkbox"/> Irregular menstrual cycle |
| <input type="checkbox"/> Endometriosis | |
| <input type="checkbox"/> Pelvic pain | |
| <input type="checkbox"/> Pregnancy: number of: _____ pregnancies _____ children | |
| <input type="checkbox"/> Currently pregnant: Current term _____ | |
| <input type="checkbox"/> Take birth control? How long? _____ | |

Any other information about pregnancies, complications with delivery, menstrual problems?

Patient Signature

Date

Please let your Bluegrass Doctor of Physical Therapy know if there is any other information that you feel is important for us to know.