



Name: _____

Date: _____

Leisure activities, including exercise routines: _____

Occupation, including activities that comprise your workday: _____

Age: _____ Height: _____ Weight: _____

Are you on a work restriction from your doctor? Yes No Are you latex sensitive? Yes No

Do you smoke? Yes No Do you have a pacemaker? Yes No

FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No

Have you RECENTLY noted any of the following (check all that apply)?

- | | | |
|---|---|---|
| <input type="checkbox"/> fatigue | <input type="checkbox"/> numbness or tingling | <input type="checkbox"/> constipation or diarrhea |
| <input type="checkbox"/> fever/chills/sweats | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> skin changes |
| <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> dizziness/lightheadedness | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> weight loss/gain | <input type="checkbox"/> heartburn/indigestion | <input type="checkbox"/> fainting |
| <input type="checkbox"/> difficulty maintaining balance while walking | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> cough |
| <input type="checkbox"/> falls | <input type="checkbox"/> changes in bowel or bladder function | <input type="checkbox"/> headaches |

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|---|---|--|
| <input type="checkbox"/> cancer | <input type="checkbox"/> depression | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> lung problems | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> chest pain/angina | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> asthma | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> circulation problems | <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> other arthritic condition | <input type="checkbox"/> eye problem/infection |
| <input type="checkbox"/> stroke | <input type="checkbox"/> bladder/urinary tract infection | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> anemia | <input type="checkbox"/> kidney problem/infection | <input type="checkbox"/> liver problems |
| <input type="checkbox"/> bone or joint infection | <input type="checkbox"/> sexually transmitted disease/HIV | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> chemical dependency (i.e., alcoholism) | <input type="checkbox"/> pelvic inflammatory disease | <input type="checkbox"/> pneumonia |

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|--|-------------------------------------|---|
| <input type="checkbox"/> cancer | <input type="checkbox"/> diabetes | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> stroke | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> depression | <input type="checkbox"/> blood clots |

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Is this something with which you would like help? YES YES, BUT NOT TODAY NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Have you ever taken steroid medications for any medical conditions? YES NO

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

What date (roughly) did your present symptoms start? _____

What do you think caused your symptoms? _____

My symptoms are currently: Getting Better Getting Worse Staying about the same

I should not do physical activities that might make my pain worse: Disagree Unsure Agree

Treatment received so far for this problem (chiropractic, injections, etc) _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

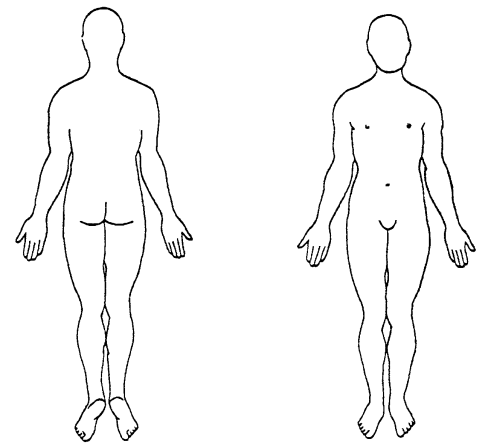
Have you ever had this problem before: Yes No When _____ Treatment rec'd _____

How long did it take for you to feel better? _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

- ↓ Shooting/sharp pain
- Dull/aching pain
- ||| Numbness
- = Tingling



My symptoms currently: Come and go Are Constant Are constant, but change with activity

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. _____
2. _____
3. _____

How are you currently able to sleep at night due to your symptoms?

No problem sleeping Difficulty falling asleep Awakened by pain Sleep only with medication

When are your symptoms worst? Morning Afternoon Evening Night After exercise

When are your symptoms the best? Morning Afternoon Evening Night After exercise

Using the 0 to 10 the scale, with 0 being “no pain” and 10 being the “worst pain imaginable” please describe:

Your current level of pain while completing this survey: _____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____



CURRENT MEDICATION LIST

Date: _____

PATIENT INFORMATION

First Name		Last Name		Date of Birth	
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KNOWN MEDICATION ALLERGIES

PLEASE LIST ALL MEDICATIONS/SUPPLEMENTS/VITAMINS INCLUDING DOSE

Medication/Supplement/Vitamins Name	Dose / How Often	Oral, Injection, Topical etc...



I hereby agree to be evaluated by Willem Verweij Physical Therapy, LLC and agree to such treatment that in the opinion of the physician(s) and therapist(s) is necessary.

I understand that it is my responsibility to obtain any insurance referrals prior to my first Physical Therapy appointment. If I schedule and attend my appointments without proper insurance referrals, I understand that I will be accepting financial responsibility for each visit without a referral.

I understand that it is my responsibility to verify Physical Therapy coverage with my insurance carrier(s) and that I am financially responsible for charges not covered by my insurance carrier.

I understand that it is the policy of Willem Verweij Physical Therapy, LLC to ask for backup insurance for all workers' compensation patients in the event the workers' comp claim is denied. I also understand that it is my responsibility to obtain any health insurance referrals for this backup insurance prior to my first appointment. If no referral is available, and my workers' comp claim is denied, I will be held liable for all charges.

Assignment of Insurance Benefit (Medicare included) and Release of Information

- I authorize and request payment of medical benefits directly to Willem Verweij Physical Therapy, LLC.
- I authorize the release of any medical information necessary to process my Insurance claim(s).
- I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.
- I agree that a photocopy of this form may be used in lieu of the original.

Signature: _____ **Date:** _____

Statement of Financial Responsibility

I accept financial responsibility for any and all charges incurred at Willem Verweij Physical Therapy, LLC including (but not limited to) any balances which may not be covered by my insurance, such as my deductible, coinsurance, co-payments and the balance of the usual and customary fee. This balance is payable at the time of service or upon receipt of statement.

Signature: _____ **Date:** _____



Acknowledgement of Receipt of Notice

I have received the Notice of Privacy Practices provided by Willem Verweij Physical Therapy, LLC. I understand that the terms of this notice may change and I may receive a copy of a revised notice by contacting Willem Verweij Physical Therapy, LLC located at 36 Industrial Way, Suite 1, Rochester, NH 03867.

Patient Name

Patient Signature

Date

.....

I authorize _____

(spouse, parent etc please print their full name)

**To receive my medical and billing information from
Willem Verweij Physical Therapy, LLC.**

Patient Signature

Date