Bay Physical Therapy and Sports Rehabilitation Center, Inc. dba
Bay Physical Therapy and Fitness Center
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Ph 831-375-5909 Fax 831-375-7259

Patient Name: _____ Today's Date: _____

Patient History Intake Form

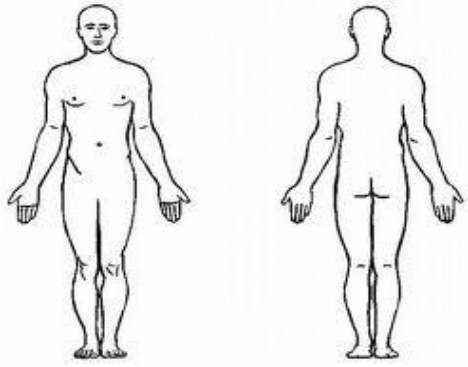
1. Please describe the problem that brings you here, along with how and when it happened.

_____
_____
_____
_____

2. Please check whether this problem is O Chronic (meaning persisting for a long time or constantly recurring) or
   O Acute (meaning a rapid onset and occurred recently.)
3. Date of Injury:_____ Please be specific as possible. Approx. Time:_____
4. Date of Surgery, if any:_____
5. What makes the problem feel worse? _____
6. What makes the problem feel better? _____
7. What treatment have you had for this problem?
   (X-Ray, MRI, Injections, Medications, acupuncture, chiropractic, etc.)
   _____
8. Date and location of last imaging test?
   _____
9. Current medications and supplements:
   _____
   _____
10. Does the discomfort disturb your work? Circle one: Yes/No If yes, please describe how:_____
    _____
11. Does the discomfort disturb your sleep? Circle one: Yes/No If yes, please describe how:_____
    _____
12. On a scale of 1-10 with 10 being the worst pain, please rate the pain level you have today /10
13. How would you describe the symptoms that you are experiencing? Circle all that apply

    Numbness Pins & Needles Burning Stabbing Aching

14. On the drawing below, please indicate the painful areas on your body that we will be treating by circling them



15. Do you have any of the following conditions? Circle all that apply

- High blood pressure
- Heart problems
- Vascular problems
- Back problems
- Kidney problems
- COPD
- Previous accidents
- Diabetes
- Stroke

- Cancer
- Seizures
- Metal implants
- Osteoporosis
- Anxiety
- Depression
- Chronic headaches
- Neurological disease
- Arthritis
- Allergies/Asthma
- Allergies to heat or ice

16. Are your currently or could you be pregnant? Yes/No
17. Please describe your occupation and activities at home:

_____
_____
_____
_____

18. Is there anything else you would like your physical therapist to know about?

_____
_____
_____
_____

19. Do you have an attorney representing you in a personal injury or workers compensation case? Y/N
If so, please provide contact information here:

_____

_____

20. Is there a person whom you would like to have access to information about your treatment, appointment dates and times or to communicate with our office on your behalf? Yes/No (circle one)

Name: _____ Phone: _____

Please list exactly what information may be shared with this person: (if it is not listed below-it will not be shared)

_____
_____

21. I have received a copy of the "Notice of Privacy Practices" _____(initial)

Patient Demographic Information

Name: _____ DOB: _____ Age: _____

Social Security Number: _____-_____-_____ (Required for Workers comp and blue cross/blue shield patients)

Email Address: _____
(Providing an email address will register you for our quarterly newsletter and provide another means of contact)

Driver's License Number: _____ Issue State: _____

Home Address: _____

Home Phone: ( ) - Cell Phone: ( ) -

Insurance Subscriber information: (If you, the patient, are the subscriber please put "self")

Name: _____ Date of Birth: _____

Subscriber relationship to patient: Spouse/Child/Other:_____

Referring Doctor Name: _____

Employer (required): _____

Employer Address: _____

Occupation (required): _____ Work Number_____

An emergency contact is required below: This person will be contacted in the event that we cannot reach you or there is an emergency during an office visit:
Emergency Contact Name: _____

Phone Number: ( ) - Relationship: _____

I hereby authorize my insurance carrier to directly pay Bay Physical Therapy for all professional and medical services rendered to me. This is a direct assignment of my rights and benefits under my policy. I agree to pay in a timely manner and understand all copayments, coinsurances, and deductibles will be collected at the time of service. If I cancel within less than 24 hours or "no show"(Meaning do not call to cancel or come in to keep appointment)I fully understand I will be charged and required to pay a $50.00 fee, payable before making any subsequent appointments. A photocopy of this shall be considered valid and effective. I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in my case. I agree that regardless of my insurance status, I am responsible for any unpaid balance on my account for services rendered. I certify that this information is true and correct to the best of my knowledge. HIPAA

_____ _____
Signature Date

If under 18: _____ _____
Guardian name and signature Date