Symmetry Physical Therapy

13890 Palmdale Road,
Victorville, CA 92392
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Patient Information

Patient's First and Last Name *Nombre y Apellido del Paciente*		DOB *Fecha de Nacimiento*	Age *Edad*
Patient's SSN *Numero de Seguro del Paciente*	Drivers Lic. # *Numero de Licencia de conducir*	Marital Status *Estado civil*	Sex *Sexo*
Street Address *Direccion Fisica*		City *Ciudad*	State *Estado*
Zip Code *Codigo Postal*	Daytime Phone *Telefono de dia*	Cellphone *Telefono Celular*	
Email Address *Direccion de correo electronico*			
Mailing Address *Direccion Postal*		City *Ciudad*	State *Estado*
Employer *Empleador*		Address *Direccion*	
Occupation *Ocupacion*		Work Telephone *Telefono del Trabajo*	
Emergency Contact *Contacto de Emergencia*	Relationship *Relacion*	Phone *Telefono*	
Name of Sponsor *El Nombre del Patrocinador*	Sponsor's SSN *Numero de Seguro del Patrocinador*		

1. **CONSENT TO TREATMENT.** The undersigned consents to any medical treatment rendered to above named patient that may be considered advisable and necessary in the judgment of the Physical Therapist.
   CONSENTIMIENTO PARA EL TRATAMIENTO. *El abajo firmante consiente a los servicios medicos prestados a el paciente antes mencionado que se puede considerer conveniente y necesario a juicio del Fisioterapeuta.*

2. **RELEASE OF INFORMATION.** The undersigned agrees that Symmetry Physical Therapy may release medical records and other information necessary to secure payment from employers, insurance companies, health care service plans or Workers Compensation carries.
   DIVULGACION DE INFORMACION. *EL abajo firmante esta de acuerdo en que Symmetry Physical Therapy puede dar a conocer los registros medicos y otra informacion necesaria para garantizar el pago de los empleadores, las empresas de seguro, las empresas de planes de servicio de atencion medica o Compensacion a los trabajodores.*

3. **PAYMENT TERMS AND ASSIGNMENT OF BENFITS**. The undersigned authorizes payment to the above provider of benefits due me under any terms of any insurance policy or policies that may cover provider's professional services rendered to the above named patient. I understand that I am financially responsible to the provider for services not paid by said insurance policies. This responsibility includes services rendered but not authorized by the patient's health insurance plan or when the provider is not contracted provider with the health insurance.
   CONDICIONES DE PAGO Y ASIGNACION DE LOS BENEFICIOS. *El abajo firmante autoriza el pago al proveedor por encima de las prestaciones por mi bajo los terminos de cualquier poliza de seguro o politicas, que pueden cubrir los servicios profesionales del proveedor prestados a el paciente antes mencionado. Entiendo que soy financieremente responsable ante el proveedor de servicios no pagados por dicha poliza de seguro. Esta responsabilidad incluye los servicios prestados pero no autorizados por el plan de seguro del paciente o cuando el proveedor no tiene contrato professional con el plan de seguro de salud.*

4. **CHARGE FOR NO SHOW/CANCELLATION WITHOUT 24 HOUR NOTICE.** I understand that 24 hour notice is required for cancelling an appointment, and I will be charged a $25 fee for any missed appointment without required notification. I also understand that I will be responsible for this charge and that my insurance company will not be billed for that day.
   SI NO SE PRESENTA / CANCELACION SIN PREVIO AVISO DE 24 HORAS. *Entiendo que se requiere un aviso de 24 horas para cancelar una cita, y se me cobrara $25 por cualquier cita perdida y sin notificacion. Tambien entiendo que sere responsable de este cargo y que mi compañía de seguro no sera cobrado por ese dia.*

Signature _____ Date _____
Firma *Fecha*

Symmetry Physical Therapy

PATIENT QUESTIONNAIRE

1. **Is this a work injury?**
   - **a.** Yes. **Date of Injury.**_____
   - **b.** No. (If it is not a work injury, skip to question number #2)
   - **c.** What is your occupation? _____

   If this is a work injury, what describes your status?
   - a. Full duty
   - b. Modified duty.
   - c. Off work.
   - d. I am no longer employed.
   - e. Retired.
   - f. None applies to me
   - g. Other _____

2. **What is the mechanism or reason for your condition / injury? Please circle all that applies.**
   - a. Fall / Assault
   - b. Motor vehicle accident.
   - c. Repetitive motion from work / Work related tasks
   - d. Repetitive motion from sports / Sport Injury
   - e. Chronic injury/old injury
   - f. Arthritic changes / Degenerative changes
   - g. Stroke / Prolonged inactivity caused weakness / Spinal cord injury.
   - h. No reason, just started having pain.
   - i. Other. Please explain_____
     _____

3. **Did you have surgery pertaining ONLY to this referral?**
   - **a.** Yes. **Date of Surgery:** _____ **b.** No.

4. **What type of surgery did you have pertaining ONLY to this referral?**
   _____

5. **What surgery have you had in the past?** **Circle:**
   - **a.** Total knee replacement. **R** or **L**
   - **b.** Total hip replacement. **R** or **L**
   - **c.** Shoulder replacement. **R** or **L**
   - **d.** Neck fusion with metal cage.
   - **e.** Neck fusion with no metal.
   - **f.** Back fusion with metal.
   - **g.** Back fusion with no metal.
   - **h.** I have not had any surgery.
   - **i.** Unsure.
   - **j.** Other surgeries _____

6. **How long have you been experiencing your condition?**
   - **a.** Less than a month.
   - **b.** More than 6 months.
   - **c.** More than a year
   - **d.** It is longer than 5 years

7. **Do you have pain?**
   a. Yes. **b.** No

8. **Where is your pain?**

   _____

9. **How will you grade your pain level?**
   a. 0-4 Mild.
   b. 5-7 Moderate
   c. 8-10 Severe.

10. **What is the type of pain you are experiencing? Please circle all that applies.**
    a. Dull.
    b. Throbbing.
    c. Sharp.
    d. Radiating pain / pain that travels.
    e. Burning sensation.
    f. Numbness / Tingling / Neuropathy
    g. Hurts when I move.
    h. Constant Pain / Intermittent pain (Comes and goes)

11. **How are you coping with pain? Please circle all that applies.**
    a. I am unable to function.
    b. I am in bed all the time.
    c. I try to keep as active despite pain.
    d. I am functional with pain but I suffer at night or morning.
    e. Medication helps me on a day to day basis.

12. **What is difficult to do with your condition? Please circle all that applies.**
    a. Getting dressed / bathing / prepping meals.
    b. Driving.
    c. Walking.
    d. Unable to work to full capacity.
    e. Unable to find work.
    f. Any additional difficulty _____

13. **Do you have weakness or paralysis on any part of your body?**
    a. Yes. **If so, which part is weak?** R or L **b.** No

14. **Have you lost your balance and sustained a fall in the past 3 months?**
    a. Yes. **b.** No

15. **Do you fatigue easily?**
    a. Yes. **b.** No

16. **Do you experience dizziness when standing up for the first time?**
    a. Yes. **b.** No

17. **Do you take mediation for pain?**
    a. Yes, it helps me on a day to day basis. **b.** No

18. **Do the medications help with your pain?**
    a. Yes. **b.** No

19. **Do you have any of the following?**
    a. Pacemaker.
    b. Blood clots.
    c. Need assistance with all transfers.

20. Do you have the following conditions? Please circle all that applies.

- **a.** Diabetes.
- **b.** High blood pressure.
- **c.** Heart disease.
- **d.** Pace marker.
- **e.** Repeated falls at home.
- **f.** Rheumatoid / Osteoarthritis
- **g.** Chronic Headaches.
- **h.** Hernia.
- **i.** Pregnancy **At this time** (0-1-2-3-4-5-6-7-8-9 months)
- **j.** Cancer.
- **k.** Allergies.
- **l.** Not Applicable / None of the above

21. Have you had Physical Therapy at another location with this condition?

a. Yes. **If yes, how many visits?** _____ **b.** No, first time

22. How would you describe your activity level?

- **a.** Sedentary.
- **b.** Mildly active.
- **c.** Moderately active / I am still working.
- **d.** I run marathons.

23. Do you have any skin allergies to the following? NO

- **a.** Latex.
- **b.** Vinyl.
- **c.** Adhesives from band aids.

24. Do you utilize any of the following assistive devices? NO

- **a.** Cane.
- **b.** Walker
- **c.** Hemi walker.
- **d.** Handheld assist by people.
- **e.** Mostly in wheelchair.

25. What is your goal with therapy?

- **a.** Decrease my pain.
- **b.** Increase my strength.
- **c.** Increase my range of motion.
- **d.** Increase my overall conditioning.
- **e.** Improve my walk.
- **f.** Improve my posture.
- **g.** Improve my balance.
- **h.** All of the above.

26. Do you have MRI / X-Ray reports?

a. Yes **b.** No

NAME: _____ **DATE:** _____

SIGNATURE: _____ **DOB:** _____

Email Address:_____ AGE: _____

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NOTICE OF PRIVACY PRACTICES:
Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Symmetry Physical Therapy. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our Notice, you may obtain a copy of the revised Notice by contacting our facility.

I acknowledge receipt of the *Notice of Privacy Practices* of Symmetry Physical Therapy, Inc.

Signature:_____ Date:_____

Print Name:_____