

PATIENT INFORMATION			EMAIL ADDRESS: _____		
First Name:	Last Name:	Middle Initial:	Date: / /		
Address:		City:	State:	Zip:	
Birth date: / /	Age:	Male Female	S.S. #: - -		
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -		Spouse:		
Chose Clinic Because/ Referred to Clinic By Dr.:			Insurance Plan Family Friend		
Former Patient Close to Work/Home Website Yellow Pages Street Sign Other:					
WORK INFORMATION					
Employer:			Work Phone ( ) -	Ext.	
Occupation:		Employment Status Full Time Part Time Retired Not Employed			
CARE PROVIDER INFORMATION					
Referring Dr:			Referring Dr. Phone: ( ) -		
Regular Dr./PCP			Regular Dr./PCP Phone: ( ) -		
INSURANCE INFORMATION			( PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST )		
Primary Insurance Name:					
Subscriber's Name (If different):				Birth date : / /	
ID. #:	Group/Policy #				
Patient's Relationship to Subscriber: Self Spouse Child Other:					
Name of Secondary Insurance:					
Subscriber's Name:				Birth date : / /	
ID. #:	Group/Policy #				
Patient's Relationship to Subscriber: Self Spouse Child Other:					
AUTO OR WORK INJURY CLAIM			( PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP )		
Insurance Name: Auto :			Labor & Industries:		
Adjuster/Claim Manager:			Phone:	Ext.:	
Address:		City:	State:	Zip:	
Claim #:	Accident Date: / /		Cause:		
ATTORNEY INFORMATION					
Name:		Law Firm:	Phone: ( ) -		
Address		City:	State:	Zip:	
IN CASE OF EMERGENCY					
Name of Local Friend or Relative (Not Living at Same Address):					
Relationship to Patient:		Home Phone: ( ) -	Work Phone: ( ) -		

I authorize my insurance benefits be paid directly to STL Pain & Physical Therapy. I understand that I am financially responsible for any balance. I also authorize STL Pain & Physical Therapy to release any information required to process my claims.

**PAST MEDICAL HISTORY FORM**

**Patient Name** \_\_\_\_\_

BLOOD PRESSURE			JOINT CONDITIONS		
YES	NO		YES	NO	
		Hypertension			Upper Extremity
		Low Blood Pressure			Dislocation
		Normal Blood Pressure			Lower Extremity Dislocation
HEART DISEASE			OTHER CONDITIONS		
YES	NO		YES	NO	
		Heart Attack			Muscular Dystrophy
		Atherosclerotic Disease			Rheumatoid Arthritis
		Myocardial Infarction			Multiple Sclerosis
		Rheumatic Heart Disease			Epilepsy
		Heart Murmur			Gout
		Do you have a pacemaker			Fibromyalgia
MUSCLE CONDITION					Diabetes
YES	NO				Hearing Loss
		Carpal Tunnel R/L			Poor Eyesight
		Tennis Elbow R/L			Fainting
		Back/Neck Problems			Cancer (presently or history of)
		Limited Limb Movement			Other: _____
LUNGS					_____
YES	NO				_____
		Asthma			_____
		Emphysema			_____
		Shortness of Breath			_____

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
None	Sitting	Low	Smoking	Packs a Day _____
1-2 x Week	Standing	Medium	Alcohol	Drinks a Week _____
3-4 x Week	Light Labor	High	Coffee/Soda	Cups a Week _____
5+ x Week	Heavy Labor			

What types of exercise do you perform?

:

What things cause stress in your life? :

Are you taking any seizure medication? YES NO If yes list name: \_\_\_\_\_

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

YES NO If yes list name: \_\_\_\_\_

List all medications you are currently taking:

List all surgeries in the past two years (Including dates): \_\_\_\_\_

Are you pregnant? YES NO What week?: \_\_\_\_\_

Have you had any injuries related to work? YES NO If yes list body part and date.: \_\_\_\_\_

Have you had any Auto Accidents YES NO If yes list body part and date.: \_\_\_\_\_

Have you had Physical Therapy or Massage Therapy before? YES NO Where: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient, Parent, Guardian, Personal Representative

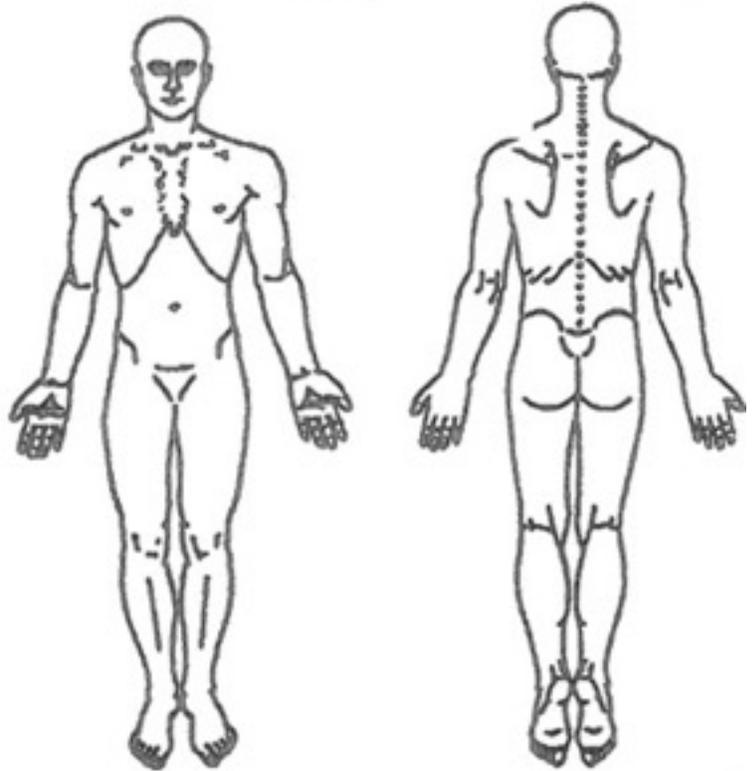
\_\_\_\_\_  
Date

# Pain and Symptom Status Report

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing



**Ache**  
MMM  
M

**Burning**  
— — —  
— —

**Numbness**  
O O O O  
O O O

**Fins and Needles**  
□ □ □ □ □ □ □ □ □ □  
□ □ □ □ □ □ □ □ □ □

**Stabbing**  
/ / / / / / / /  
/ / / / /

**Other**  
x x x x  
x x x

## Chief Complaint and Visual Analog Scale

My Chief Complaint is: \_\_\_\_\_

Date First Symptom of your problem occurred on: \_\_\_\_\_

2nd Complaint: \_\_\_\_\_

3rd Complaint: \_\_\_\_\_

**Please circle on the scale below to indicate your CURRENT level of pain:**

**No Pain**    0   1   2   3   4   5   6   7   8   9   10    **Pain as bad as it gets.**

**Please circle on the scale below to indicate your AVERAGE level of pain:**

**No Pain**    0   1   2   3   4   5   6   7   8   9   10    **Pain as bad as it gets.**

**Please circle on the scale below to indicate your WORST level of pain:**

**No Pain**    0   1   2   3   4   5   6   7   8   9   10    **Pain as bad as it gets.**

Additional Comments: \_\_\_\_\_