350 NW 70 Avenue, Suite A
Plantation, FL 33317
(954) 741-2221
(954) 741-2155
info@PhysicalOne.com
physicalone.com/

1. Dear Guest,

   PhysicalOne™ was created for you; to offer you an exceptional physical therapy experience including excellent clinical care, the latest in therapeutic techniques and technology, and exceptional service; all in a pleasant and welcoming setting.

   Please take a moment to provide us with the most accurate and up-to-date information about you and about your condition.

2. I will be visiting PhysicalOne to receive (check all that apply):
   ☐ Physical Therapy ☐ Medical Massage ☐ Wellness and Fitness ☐ Yoga Therapy

   My condition was initiated in
   ○ An accident at work ○ A car accident
   ○ An accident not related to work or involving a car
   ○ Not in an accident

3. If an accident that is neither a car accident nor an accident at work, please provide details:

   ____

4. **Please enter your information:**

   ○ Mr. ○ Ms. ○ Dr.

   First Name: ________ Middle Initials: ________ Last Name: ________ Date of Birth: ________

   Gender:
   ○ Female ○ Male

   Preferred Name: ________ Referred to PhysicalOne™ by: ________

   Local Address: ______________________________

   City: ________ State: ________ Zip Code: ________

   Mobile Phone: ________ Home Phone (at Local Address): ________ Work Phone: ________

   Email: ______________________________

   Permanent Address (If different from Local Address): ______________________________

   Primary Languages:
   ○ English ○ Spanish ○ Other

   If Other, Please Specify: ________

I am authorizing PhysicalOne™ to contact me by (check all that Apply):
☐ Mobile Phone ☐ Home Phone ☐ Text Message
☐ Email

I am authorizing PhysicalOne™ to leave detailed messages at (check all that apply):
☐ Mobile Phone ☐ Home Phone

5. **In case of emergency, I authorize PhysicalOne™ to call:**

Title:
○ Mr. ○ Ms. ○ Dr.

First Name: ____________________

Last Name: ____________________

Relation to Me: ____________________

Additional Phone Number: ____________________

Preferred Phone Number: ____________________

I am authorizing PhysicalOne™ to leave a message at (check all that apply):
☐ Preferred Phone Number
☐ Additional Phone Number

6. **Employment**

Please select:
○ Full-Time ○ Part-Time ○ Retired ○ Unemployed ○ Student ○ Disabled

Employer/School: ____________________

Employer/School Phone: ____________________

Employer/School City: ____________________

7. **Insurance Information:**

I am a Medicare Beneficiary/Patient:
○ Yes ○ No

Primary Insurance Company: ____________________

Member ID / Group ID: ____________________

Policy Holder:
○ Self ○ Spouse
○ Parent

Secondary Insurance Company: ____________________

Member ID / Group ID: ____________________

Policy Holder:
○ Self ○ Spouse
○ Parent

8. **For MEDICARE Beneficiaries/Patients Only (skip if you are not a Medicare Beneficiary)**

In the past three (3) months, I received therapy for the condition I would like PhysicalOne™ to treat:
○ Yes ○ No

If Yes, I received the therapy in the following dates: ____________________

I am currently receiving Home Health care:
○ Yes ○ No

If yes: Home Health Agency ____________________

Phone Number: ____________________

I am currently receiving treatment by another rehab provider:
○ Yes ○ No

If yes: Provider Name: ____________________

Phone Number: ____________________

9. **My Current Condition:**

The main reason/problem for my visit to PhysicalOne™ today is:

____

____

This is how this problem began:

____

I have this problem for:
○ A few days ○ A few weeks ○ A few months ○ About a year or two ○ More than two years

A number of tests/diagnostic procedures were already done for this problem:
○ Yes ○ No

I have the results of these tests:
○ No ○ Yes, but not all of them ○ Yes, all of them

Because of this problem, I have difficulties doing these activities:

____

I am currently dealing with this problem by doing the following:

____

Additional information on my problem:

____

10. My Height is: (ft./in.) ____________________

My weight is: (lbs) ____________________

11. I am currently smoking:
○ No ○ Yes ○ I quit

12. **If yes, I smoke (packs/day):**

____

13. **If Quit, quit date:**

____

14. **My Pain:**

I feel more pain when I:

____

I feel less pain when I:

____

The pain changed my ability to work/function
○ Yes ○ No

If Yes, this is how my work or function has changed:

____

____

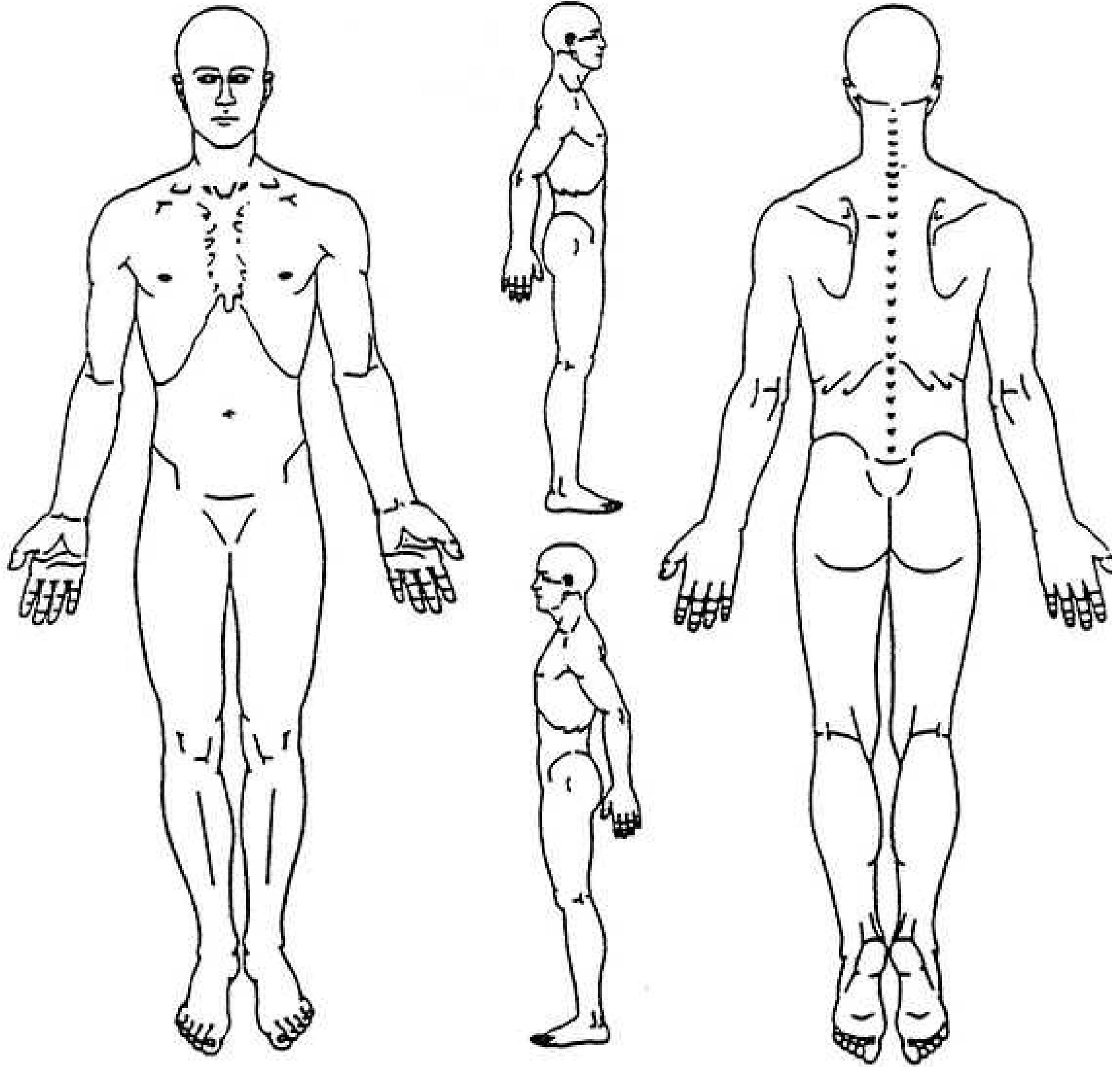
The type of pain I feel can be mostly characterized as:
○ Sharp ○ Burning ○ Dull/Achy ○ Tingling
○ Numbness ○ Other

If other, please specify:

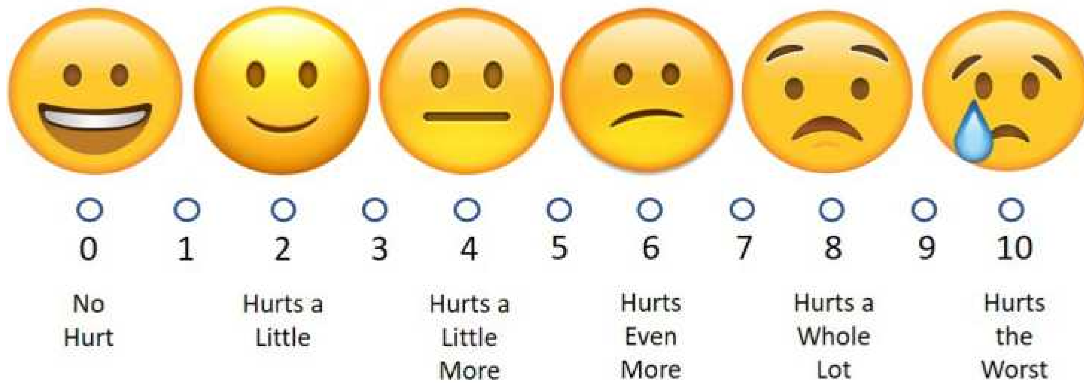
I have the pain
○ Constantly ○ Frequently ○ Intermittently
○ Occasionally ○ Other

If other, please specify:

15. I feel pain in the areas I marked below:



16.Use this illustration to help answer the next two questions:



17. **Looking at the illustration above, select the numbers that represent your pain levels:**

At rest, my pain level is: ______________________

During motion/activity, my pain level is: ______________________

18. **My Medical Background I currently have or had in the past these conditions (check all that apply):**

- ☐ Cancer
- ☐ Heart Disease
- ☐ Chest Pain
- ☐ Kidney Disease
- ☐ Pacemaker
- ☐ Other
- ☐ High Blood Pressure
- ☐ Seizures
- ☐ Hepatitis
- ☐ Asthma/COPD
- ☐ Arthritis
- ☐ Diabetes
- ☐ Stroke
- ☐ HIV/AIDS
- ☐ Depression
- ☐ Infection

If other, please specify:

____

19. **If Infection, please specify:**

____

20. **List your medications, herbs and vitamins:**

	List Here
1	
2	
3	

21. Allergies

	List Here
1	
2	
3	

22. My past surgeries:

	Surgeries	Date
1		
2		
3		

23. Family Medical History and Conditions:

____

____

____

____

24. Special Considerations:

- ☐ Fall Risks
- ☐ THR
- ☐ Hearing Impairment
- ☐ Other

If other, please specify:

____

25. My Goals:

- ☐ Increase strength and endurance
- ☐ Lose/Maintain/Gain weight
- ☐ Improve gait and balance
- ☐ Resume home activities
- ☐ Learn to eat healthier
- ☐ Prevent injury
- ☐ Manage risk factors
- ☐ Breathe better
- ☐ Return to hobbies
- ☐ Improve posture
- ☐ Enhance performance
- ☐ Reduce pain
- ☐ Sleep better
- ☐ Enhance performance
- ☐ Take less medications
- ☐ Feel more energetic

26. If Return to hobbies, please provide details:

____

27. If Reduce pain, please provide details:

____

____

____

____

28. **My Treating Physicians:**

	Name	Practice	Phone
1			
2			
3			

Patient:

____ ____________________

Signature Date

29. **Person Filling this Form (if different from patient):**

____

Signature

____

Signature