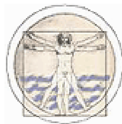
Caliente Springs  **Physical Therapy**

Name: ____

Preferred Name:_________________________ Date of Birth: ___________ Age: ________

Mailing Address: ______________________ City: __________ State:_____ Zip: __________

Primary Phone: _______________________ Secondary Phone: ________________________

In case of emergency, Contact: _________________ Relationship: ________ Phone: _________

Appointment Confirmations: Email____

OR Text. Cell Phone:___________________ AT&T. Verizon. Sprint. T-Mobile. Other: ________

Referring Physician: _____________________________ Surgery? Yes / No Date: __________

Employer:__________________ Occupation: _____________ Presently Working? Yes / No

Work Injury? Yes / No Motor Vehicle Accident? Yes / No Personal Injury Claim? Yes./No

Why have you come for physical therapy?_______________________________________

Just prior to this onset were you completely free of symptoms? Yes / No Date of Injury: ___________

Have you had anything similar before? Yes / No Previous Treatment? _______________________

Current Pain Level: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain)

What makes pain BETTER? ____

What makes pain WORSE? ____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

__Diabetes	__High Blood Pressure	__Previous Surgery	__Bad Reaction to Medicine
__Pacemaker	__Kidney Problems	__Heart Attack	__Metal Implants
__Cancer	__Respiratory Difficulty	__Osteoporosis	__Heart Disease
__Seizures	__Heat Sensitivity	__Cold Sensitivity	__Circulatory Disorders
__Dizziness	__Nervous Disorders	__Pregnancy (Past)	__Pregnancy (Current)
__Headaches	__Allergies to Medicine__________________		__Other Allergies______________

__Other Illness____

PLEASE EXPLAIN ANY MARKED ITEMS AND INCLUDE APPROXIMATE DATES:__________

____

____

Are you taking any medications? (Please list) ____

Is there anything else we should know? ____

______ **I understand I will incur a <u>$45 charge</u> for <u>missed</u> appointments or appointments <u>cancelled</u> within 24 hours.**
(Initial)

I am personally responsible to CSPT for payment of any charges I incur, regardless of my insurance coverage.
I authorize payment of medical benefits directly to CSPT, Inc. for services rendered. I authorize the release of the medical information necessary to process my claim. The undersigned acknowledges and agrees that the information set forth is true and correct.

Patient Signature: ____ Date: _____________