

Caliente Springs



Physical Therapy

Name: _____

Preferred Name: _____ Date of Birth: _____ Age: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Social Security #: _____ Date of Injury: _____

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

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?

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Previous Surgery | <input type="checkbox"/> Bad Reaction to Medicine |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Metal Implants |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Respiratory Difficulty | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Heat Sensitivity | <input type="checkbox"/> Cold Sensitivity | <input type="checkbox"/> Circulatory Disorders |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Pregnancy (Past) | <input type="checkbox"/> Pregnancy (Current) |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Allergies to Medicine | <input type="checkbox"/> | <input type="checkbox"/> Other Allergies _____ |
| <input type="checkbox"/> 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 \$30 charge for missed appointments or appointments cancelled 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: _____