SEATTLE'S ELITE
PHYSICAL THERAPY

Personal Information

Name: _____ Date of Birth: _____

Address _____

Email: _____

Home Phone: _____ Cell Phone: _____

Marital Status: Single ☐ Married ☐ Other ☐ Partner's Name: _____

Live Alone ☐ Live with Family ☐ Live with roommates ☐ Other: _____

Emergency Contact (Relationship): _____ Phone: _____

Insurance Information

Primary Insurance: _____ Insurance ID#: _____

Cardholder's Name (if not self): _____ Date of Birth: _____

Secondary Insurance: _____ Insurance ID#: _____

Cardholder's Name (if not self): _____ Date of Birth: _____

Fill out the following only if applicable:

Worker's Compensation or Motor Vehicle Accident (PIP)

Date of accident: _____ Claim number: _____

Claims Adjuster Contact:

Name: _____

Company: _____

Phone: _____ Fax: _____

Email: _____

Nature of Injury

Location of Injury / Symptoms: _____ Date of Injury/ Symptom onset: _____

Is this a reoccurring injury? Yes ☐ No ☐ Date of Prior Occurrences: _____

Do you have a referral from a physician for Physical Therapy? Yes ☐ No ☐

Referring Physician: _____ Primary Physician: _____

Were you referred to us by someone other than your physician? _____

Signature of Patient or Legal Guardian | Relationship of Legal Guardian | Date

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General Health Questionnaire

Patient: _____ Age: _____

Diagnosis or Problem Area: _____

Please complete this questionnaire so that we can provide you with the best possible care. Check any problems below that you have now and/or have had trouble within the past, and please check if you have a family history.

Self	Family		Self	Family	
____	____	Chest Pain	____	____	Osteoarthritis
____	____	Heart Disease	____	____	Rheumatoid Arthritis
____	____	High/ Low Blood Pressure	____	____	Hepatitis
____	____	High Cholesterol	____	____	Blood Clots
____	____	Poor Circulation	____	____	Diabetes
____	____	Difficulty Breathing	____	____	Bleeding/ Bruising Easily
____	____	Tuberculosis	____	____	Hearing Impairment
____	____	Respiratory Disease	____	____	Visual Impairment
____	____	Numbness to Hands and Feet	____	____	Skin Rash / Disease
____	____	Head Injury	____	____	Dizziness
____	____	Stroke	____	____	Cancer
____	____	Seizures	____	____	Allergies
____	____	Difficulty with Balance	____	____	Osteoporosis
____	____	Frequent Falls	____	____	Bowel/ Bladder Problems
____	____	Blackouts	____	____	Headaches

Have you experienced any of the following in the past 3 months?

Change in health	Yes ____	No ____		Change in appetite	Yes ____	No ____	
Nausea / Vomiting	Yes ____	No ____		Difficulty swallowing	Yes ____	No ____	
Fever / Chills / Sweats	Yes ____	No ____		Night pain	Yes ____	No ____	
Unexplained weight change	Yes ____	No ____		Unusual fatigue	Yes ____	No ____	

Do you smoke? _____ If so, how much? _____

Do you drink alcohol? _____ If so, how much? _____

Do you exercise? _____ If so, how often? _____

Do you get short of breath with exertion (up/down stairs)? _____

Women, is there any chance of pregnancy? _____

Do you have any other orthopedic injuries? _____

Please list any surgeries or hospitalizations: _____

Please list (or bring in a copy of) any medication or supplements you are currently taking: _____

_____

Do you have any other special problems / concerns we should know about? _____

_____

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On the scales below, please indicate the number which best represents the severity of your pain.

Currently

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain imaginable

Least amount of pain since beginning of issue

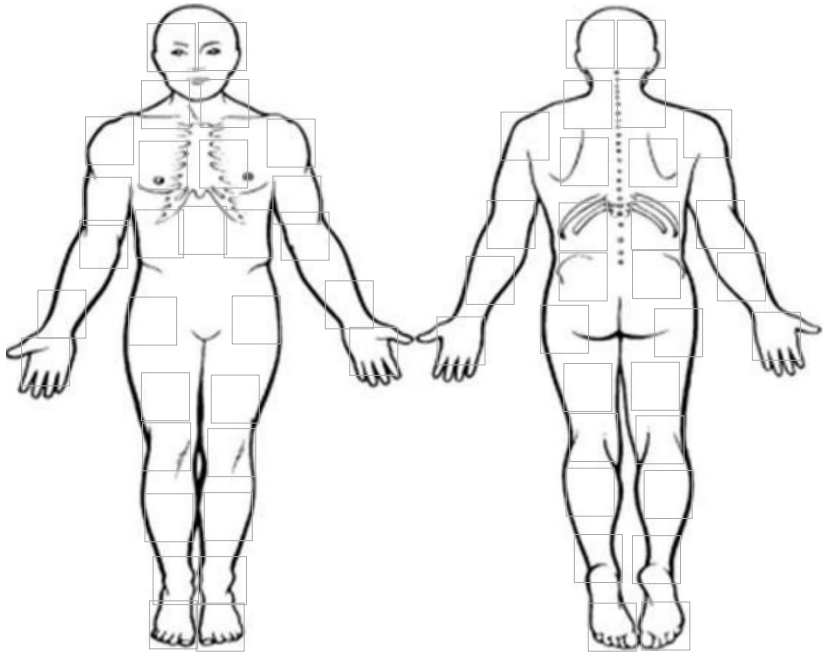
No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain imaginable

Most amount of pain since beginning of issue

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain imaginable

Body Chart:

Please mark the areas where you feel pain on the chart to the right.



Please indicate the number below which best represents your overall average level of function.

Cannot do anything	0	1	2	3	4	5	6	7	8	9	10	Able to do everything

What makes your symptoms better?

_____

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with because of your problem. List them below:

1:_____

2:_____

3:_____

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