

**ENCINITAS PHYSICAL THERAPY**  
**Confidential Case History**

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone (h) \_\_\_\_\_ (w) \_\_\_\_\_ Social Security No. \_\_\_\_\_  
Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer \_\_\_\_\_ Address \_\_\_\_\_  
Marital status \_\_\_\_\_ Spouse or housemate \_\_\_\_\_ No. of children \_\_\_\_\_  
Person responsible for this account \_\_\_\_\_ Telephone \_\_\_\_\_  
Referred by:  Doctor \_\_\_\_\_  Friend \_\_\_\_\_  Other \_\_\_\_\_  
In case of emergency, contact: \_\_\_\_\_ Telephone \_\_\_\_\_  
Are you here due to an accident?  Yes  No      Is this a workman's compensation injury?  Yes  No

**Insurance Information**

Name of Insurance Company \_\_\_\_\_ Telephone \_\_\_\_\_  
Address \_\_\_\_\_ ID # \_\_\_\_\_  
Group # \_\_\_\_\_ Claim # \_\_\_\_\_

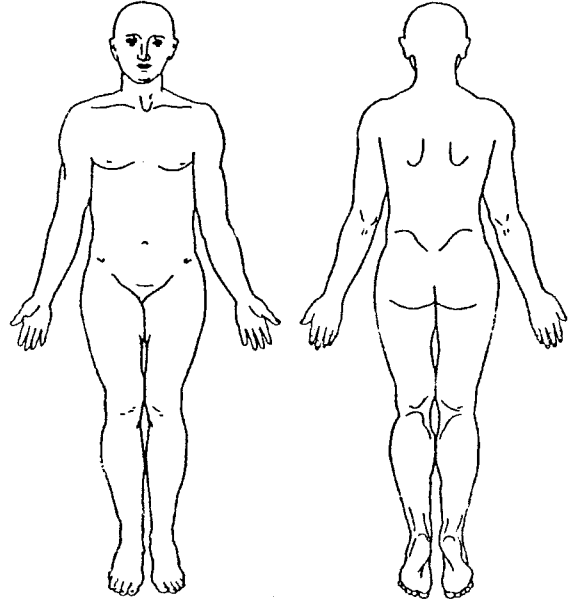
**Health Information**

1. What is the nature of your problem? \_\_\_\_\_  
\_\_\_\_\_
2. When did this problem begin? \_\_\_\_\_  
\_\_\_\_\_
3. Have you ever had this or a similar problem? If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
4. What other treatment have you had for this problem? \_\_\_\_\_  
\_\_\_\_\_
5. Please list any other doctors and therapists seen for this problem: \_\_\_\_\_  
\_\_\_\_\_
6. What other medical conditions do you have? \_\_\_\_\_  
\_\_\_\_\_
7. Please list surgical history: \_\_\_\_\_  
\_\_\_\_\_
8. What do you want to achieve through physical therapy? \_\_\_\_\_  
\_\_\_\_\_

9. What types of regular exercise do you do?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please draw in the problem area(s), labeling areas of pain, spasm, weakness, numbness and tingling:



10. What drugs or medication do you take?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Accident Information (if applicable)**

If your condition is due to an accident, please complete the following:

Did your accident occur while at work?  Yes  No      Were you in an automobile accident?  Yes  No

Date \_\_\_\_\_ Time \_\_\_\_\_ Place \_\_\_\_\_

Please describe the accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you have an attorney who has advised you in this case, please list: Name \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Is there a third party involved for insurance purposes?  Yes  No      If yes, please give party to contact:

Name \_\_\_\_\_ Address \_\_\_\_\_ Telephone \_\_\_\_\_

**Policy Statement**

1. Payment is required at time of service unless prior arrangements have been made.
2. If there is insurance coverage, co-payment is required at time of service.
3. If insurance does not pay as much as expected, the patient will be responsible for any balance due.
4. Missed appointments or cancellations without 24 hours notice will be billed the full amount.

In agreeing to receive treatment, I accept the above policy statement and agree that I am responsible for keeping my appointments and paying for services.

Signature: \_\_\_\_\_

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