Florida GulfCoast
Physical Therapy LLC

PATIENT INFORMATION SHEET

Patient Name_____ **Phone #**_____
Address (Florida):_____
City_____ **State**_____ **Zip Code**_____
Address (Not Florida):_____
City_____ **State**_____ **Zip Code**_____ **Phone #**_____
Social Security #_____ **Birth date**_____
Sex (circle one) Male Female
Marital Status (circle one) Single Married Divorced Separated Widowed
Insurance Company (Primary)_____ **ID#**_____ **Phone #**_____
Insurance Company (Secondary)_____ **ID#**_____ **Phone #**_____

Please fill out the following information if your insurance is not in your name:

Insured's Name_____ **Relation**_____ **DOB**_____
Address_____
City_____ **State**_____ **Zip Code**_____

Are you able to work?(circle) yes no **Occupation**_____ (circle) Full time Part time
Employer_____ **Phone #**_____
Address_____
City_____ **State**_____ **Zip Code**_____

Date of injury, surgery or onset of symptoms (mm/dd/yy) please be specific_____
Possible cause for injury (fall, car accident, work related):_____
If due to car accident or work, did you report the accident? (circle one) Yes No

Please fill out the following information if you were in a motor vehicle accident:

Insurance Company_____ **Phone #**_____
Address_____
City_____ **State**_____ **Zip Code**_____
Case Manager_____ **Claim #**_____
Attorney_____ **Phone #**_____
Address_____
City_____ **State**_____ **Zip Code**_____

Please fill out the following information if you sustained your injury at work:

Insurance Company_____ **Phone #**_____
Address_____
City_____ **State**_____ **Zip Code**_____
Case Manager_____ **Claim #**_____

Are you currently receiving any other treatments:_____
Are you currently receiving home health services: Yes No **If yes answer below**
Home health company name_____
Phone #_____ **Contact** _____
When was your last visit?_____ **Are they scheduled to return?** Yes No

Thank you for your cooperation. If you are unable to keep your scheduled appointments, please notify us within 24 hours before your scheduled appointment time. A $25 fee will be assessed for missed appointments without a 24 hours notice.

I have read and understand the policy regarding fees and agree to pay any remaining balance. I authorize payment directly to Florida GulfCoast Physical Therapy. I authorize consent to copy and release PT records of treatment, charges, and reports to physicians and other parties, as indicated.

What are your goals for therapy? _____

Patient Signature:_____ **Date**_____

Florida GulfCoast
Physical Therapy LLC

Phone: 239-948-2222
Fax: 239-948-2225
Web: flgulfcoastpt.com

Name_____
Diagnosis / complaint_____
Date of injury / onset of symptoms_____
Symptoms_____
Tests:(circle all that apply) **x-ray** **MRI** **CT scan** **arthrogram** **sonogram** **EMG** **NCV** **Bone density**
Results:_____
Pain description: (circle all that apply) **Sharp** **Dull** **Achy** **Shooting** **Stabbing** **Stiff** **Throbbing**
Other:_____
Do you experience: (circle all that apply) **Numbness** **Tingling** **Burning** **Weakness** **Cramping**
Other:_____

Please mark the lines below as indicated

Pain at best (0/10 = no pain, 10/10 pain = emergency)

0_____5_____10

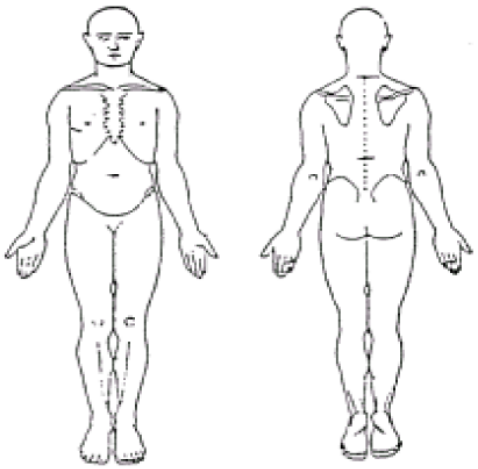
Pain at worst (0/10 = no pain, 10/10 pain = emergency)

0_____**5**_____**10**

Current pain (0/10 = no pain, 10/10 pain = emergency)

0_____**5**_____**10**

Right Left Left Right



Put an 'X' on the diagram above where you feel pain.

Is your pain: (circle) Constant Intermittent At regular intervals
Does your pain: (circle) prevent sleep wake you from sleep feel better after sleep feel worse after sleep not influenced by sleep
What increases your symptoms?_____
What decreases your symptoms?_____
Do you have any of the following: (circle)

Yes	No	**Heart condition/Heart Attack**	Yes	No	**Stroke**	Yes	No	**Diabetes**
Yes	No	**Asthma**	Yes	No	**High Blood Pressure**	Yes	No	**Low Blood Pressure**
Yes	No	**Anemia**	Yes	No	**Seizures / Epilepsy**	Yes	No	**Severe / Chronic Headaches**
Yes	No	**Arthritis**	Yes	No	**Pacemaker**	Yes	No	**Osteoporosis**
Yes	No	**Kidney Disease**	Yes	No	**Hepatitis / Jaundice**	Yes	No	**Hearing loss**
Yes	No	**Circulatory Problems**	Yes	No	**Recent Weight Gain / Loss**	Yes	No	**Dizziness / Loss of Balance**
Yes	No	**Incontinence**	Yes	No	**Pregnant**	Yes	No	**Cancer**

Other:_____
During the past 5 years have you been admitted to the hospital or had surgery?(circle) **Yes** **No** **If Yes explain:**
Date: _____ Reason: _____
Date: _____ Reason: _____
Date: _____ Reason: _____
Have you had any previous orthopedic problems, injuries or surgeries?
Date:_____ Diagnosis_____ Date:_____ Diagnosis_____ Date:_____ Diagnosis_____
Date:_____ Diagnosis_____ Date:_____ Diagnosis_____ Date:_____ Diagnosis_____

Patient Signature:_____ **Date**_____

PATIENT NAME: _____ ID#: _____ DATE: _____

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply.**

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

NECK DISABILITY INDEX – INITIAL VISIT

1. Pain Intensity
- (0) I have no pain at the moment.
- (1) The pain is very mild at the moment.
- (2) The pain is moderate at the moment.
- (3) The pain is fairly severe at the moment.
- (4) The pain is very severe at the moment.
- (5) The pain is the worse imaginable at the moment.

2. Personal Care (washing, dressing, etc)
- (0) I can look after myself normally without extra pain.
- (1) I can look after myself normally but it causes extra pain.
- (2) It is painful to look after myself and I am slow and careful.
- (3) I need some help but manage most of my personal care.
- (4) I need help every day in most aspects of self care.
- (5) I cannot get dressed, wash with difficulty and stay in bed

3. Lifting
- (0) I can lift heavy weights without extra pain.
- (1) I can lift heavy weights but it gives me extra pain.
- (2) Pain prevents me from lifting heavy weights off the floor but I can manage if they are on a table.
- (3) Pain prevents me from lifting heavy weights but I can manage if they are conveniently placed.
- (4) I can lift only very light weights.
- (5) I cannot lift or carry anything at all.

4. Headache
- (0) I have no headaches at all.
- (1) I have slight headaches which come infrequently.
- (2) I have moderate headaches which come infrequently.
- (3) I have moderate headaches which come frequently.
- (4) I have severe headaches which come infrequently.
- (5) I have headaches almost all the time.

5. Recreation
- (0) I am able engage in all my recreational activities without pain.
- (1) I am able to engage in my recreational activities with some pain.
- (2) I am able to engage in most but not all of my usual recreational activities because of my neck pain.
- (3) I am able to engage in a few of my usual recreational activities with some neck pain.
- (4) I can hardly do any recreational activities because of neck pain.
- (5) I can't do any recreational activities at all.

6. Reading
- (0) I can read as much as I want with no pain in my neck.
- (1) I can read as much as I want with slight neck pain.
- (2) I can read as much as I want with moderate neck pain.
- (3) I can't read as much as I want because of moderate neck pain.
- (4) I can hardly read at all because of severe neck pain.
- (5) I cannot read at all because of neck pain.

7. Work
- (0) I can do as much as I want to.
- (1) I can only do my usual work but no more.
- (2) I can do most of my usual work but no more.
- (3) I cannot do my usual work.
- (4) I can hardly do any usual work at all.
- (5) I can't do any work at all.

8. Sleeping
- (0) Pain does not prevent me from sleeping well.
- (1) My sleep is slightly disturbed (<1 hr sleep loss).
- (2) My sleep is mildly disturbed (1-2 hr sleep loss).
- (3) My sleep is moderately disturbed (2-3 hr sleep loss).
- (4) My sleep is greatly disturbed (3-4 hr sleep loss).
- (5) My sleep is completely disturbed (5-7 hr sleep loss).

9. Concentration
- (0) I can concentrate fully when I want with no difficulty.
- (1) I can concentrate fully when I want with slight difficulty.
- (2) I have a fair degree of difficulty concentrating when I want.
- (3) I have a lot of difficulty concentrating when I want.
- (4) I have great difficulty concentrating when I want.
- (5) I cannot concentrate at all.

10. Driving
- (0) I can drive my car without neck pain.
- (1) I can drive my car as long as I want with slight neck pain.
- (2) I can drive my car as long as I want with moderate neck pain.
- (3) I can't drive my car as long as I want because of moderate pain.
- (4) I can hardly drive my car at all because of severe neck pain.
- (5) I can't drive my car at all.

Therapist Use Only

Comorbidities:
- ☐Cancer
- ☐Diabetes
- ☐Heart Condition
- ☐High Blood Pressure
- ☐Multiple Treatment Areas
- ☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
- ☐Obesity
- ☐Surgery for this Problem
- ☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD9 Code: _____

Current Medication List

Medication	Dosage	Frequency	How is drug administered?			
			Oral	Transdermal	Suppository	Injection
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
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