Lodi: 631 S. Ham Ln. Lodi, CA 95242
P:(209) 368-7433 F:(209)368-4219
Morada: 4339 E. Morada Ln. #150 Stockton, CA 95212
P:(209) 888-6346 F: (209) 478-4939
PUMP: 220 S Church St. Lodi, CA 95240
P:(209) 365-7867 F:(209) 365-7807
"Hands on Healing, A Passion for Performance"

Patient Information Record

Name_____ Age_____ Height _____

Diagnosis_____ Weight_____

Referring Physician_____ Family Physician_____

Occupation_____ How did you hear about our clinic?_____

Please answer the following questions about your present injury or illness:

1.How and when (date) did the present injury occur?_____

2.Was the onset gradual or sudden?_____

3.Have you had a recent: MRI_____ X-Ray _____ for this problem?

4. Did you undergo surgery? _____ If yes, the date of surgery? _____

5.Were you hospitalized? _____ If yes, for how long?_____

6.Describe current symptoms:

_____

_____

Are your syptoms: Improving? _____ Worsening? _____ Not Changing? _____

What activities/positions make your symptoms: Better?_____

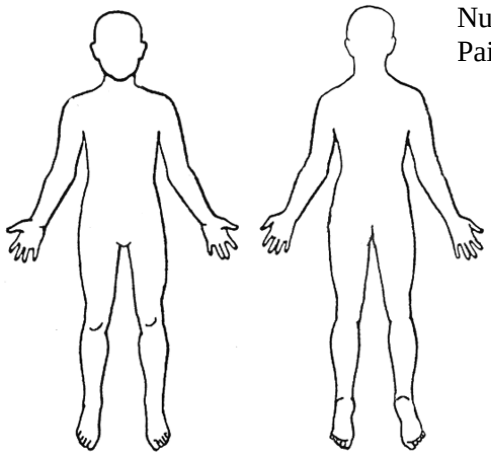
Worse?_____

Please rate your pain on a scale from 0-10 with "0"pain free and "10"worst possible pain

A.Pain level at this time _____

B.Pain at it's worse _____

C. Diagram where your symptoms are now →



Numbness- ===
Pain- ****

7.Have you ever had anything similar before?
Yes No

8.Do you have bowel or bladder problems?
Yes No

9.Have you had previous Physical Therapy or Chiropractic Treaments? Yes No

10.What are your goals for Physical Therapy?

_____

_____

Medical History

What medication are you currently taking? _____

_____

DO YOU HAVE:

High Blood Pressure?	Yes	No	Is it controlled?	Yes	No
Heart Disease?				Yes	No
Pace Maker?				Yes	No
Diabetes?				Yes	No
Bleeding/clotting disease (Hemophilia, Purpura)?				Yes	No
Dizziness, vertigo, nausea, blurred vision?				Yes	No
Respiratory illness?				Yes	No
Use of inhaled or oral steroids?				Yes	No
Metal implant(s)?				Yes	No
Current infection/fever?				Yes	No
Prostate problems?				Yes	No
Hormonal imbalance/problems?				Yes	No
Are you currently pregnant?				Yes	No
Osteoporosis?				Yes	No
Rheumatoid arthritis?				Yes	No
Allergies/material sensitivity?				Yes	No

HAVE YOU HAD:

Recent unexplained weight loss?	Yes	No
Previous head trauma or repeated convulsions?	Yes	No
Previous abdominal surgery?	Yes	No
Previous surgery for head, neck or spine?	Yes	No
Previous shoulder injury?	Yes	No
Previous knee or ankle injury?	Yes	No
Recent bone fracture?	Yes	No
Recent falls?	Yes	No
Hysterectomy?	Yes	No
History of cancer?	Yes	No

Do you exercise or perform vigorous activity at least 3 times a week? Yes No

If so, what activities? _____

Do you know of any reason why you should not participate in a regular exercise program?

_____

Please list any/all medical conditions or concerns: _____

_____

The above information is correct to the best of my knowledge.

I agree that LODI PHYSICALTHERAPY may furnish the Insurance Company with whatever information it desires concerning said PHYSICAL THERAPY services. I also agree, should the amount be insufficient to cover the entire PHYSICAL THERAPY expense, I will be responsible to said PHYSICAL THERAPIST for payment of the difference; and if the nature of the disability be such that it is NOT COVERED by the policy, I will be responsible to the PHYSICAL THERAPIST for payment of the entire bill.

Signature (parent, if minor) _____ Date _____