

Breckenridge Physical Therapy

Levon Balbay, PT, MDT

Last Name _____ First _____ MI _____

Address/PO Box _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____ email _____

DOB _____ Sex _____ M _____ F _____ Status _____ M _____ S _____ D _____

Social Security # _____

Emergency

Contact _____ Relationship _____ Phone _____

Employer _____

Occupation _____ Student _____ PT _____ FT _____

Is your injury work related _____ Auto Accident _____ Date of Injury _____

Description for visit _____

What Recreational Activities do you perform (biking, skiing, and hiking)?

How many hours a day do you participate in these activities? How many days a year? _____

Describe Your
Symptoms _____

How did your symptoms
begin? _____

Allergies: list any medication(s) you are allergic to

Are you latex sensitive Yes No List any other allergies we should know

Please check any of the following whose care you're under

Medical

Doctor _____ Osteopath _____ Dentist _____ Psychiatrist/Psychologist _____

Physical Therapist _____ Chiropractor _____ other _____

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.) _____

Have you ever been diagnosed with following conditions?

Yes No Cancer If yes describe what kind _____

Yes No Heart Problems

Yes No High Blood Pressure

Yes No Circulation Problems

Yes No Asthma

Yes No Emphysema/Bronchitis

Yes No Chemical/Dependency (i.e., alcoholism)

- Yes No Thyroid Problems
- Yes No Diabetes If yes fill out Diabetes questions below
- Yes No Multiple Sclerosis
- Yes No Rheumatoid Arthritis
- Yes No Other Arthritic conditions
- Yes No Depression
- Yes No Hepatitis
- Yes No Tuberculosis
- Yes No Stroke
- Yes No Kidney Disease
- Yes No Anemia
- Yes No Epilepsy
- Yes No Fibromyalgia
- Yes No Other explain

For Women: Are you currently pregnant or think you might be? Yes No

Diabetes Questionnaire

If you answered yes to Diabetes please answer these questions:

Do you have difficulty in maintaining your blood glucose levels with acceptable range? _____

Do your wounds heal slowly? _____

What type of insulin do you take? _____ What is your schedule?

Do you ever have episodes of hyperglycemia or insulin reaction? _____

Do you carry a source of suger? _____

FAMILY HISTORY - Has anyone in your family ever been treated for the following
Please Circle all that apply

Diabetes Cancer Tuberculosis Arthritis Heart Disease Anemia

High Blood Pressure Headaches Stroke Epilepsy Kidney Disease

Mental Illness Alcoholism (Dependency)

Please list any Surgeries or conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization

<u>Date</u>	<u>Reason for Surgery/Hospitalization</u>
1	_____
2	_____
3	_____
4	_____
5	_____

MEDICATIONS

Please list any PERSCRIPTION medication you are currently taking (including pills, injections, and/or skin patches)

1. _____	2. _____	3. _____
4. _____	5. _____	6. _____

Please list any OVER-THE-COUNTER drugs you have taken within the last week (e.g., Advil, Ibuprofen, and Tylenol)

HAVE YOU RECENTLY NOTED

- Yes No weight loss/gain
- Yes No nausea/Vomiting
- Yes No fatigue
- Yes No weakness
- Yes No fever/chills/sweats
- Yes No numbness or tingling
- Yes No Do you have trouble sleeping through the night?
- Yes No Do you feel rested in the morning?
- Yes No Are you stiff and sore in the morning?
- Yes No Do you have daytime fatigue/exhaustion?
- Yes No Can you do your regular daily activities?
- Yes No Do you have irritable bowel syndrome (e.g., nausea, diarrhea, stomach cramps)?
- Yes No Are you sensitive to temperature and humidity or changes in the weather?
- Yes No Does "brain fog" interferes with your activities?

Patient Signature _____ Date _____

Therapist Signature _____ Date _____

BRECKENRIDGE PHYSICAL THERAPY:

Patient Insurance Information:

Full Name of Patient: _____

Date of Initial Visit: _____

Primary Insurance: _____

Insured Name: _____ Date Of Birth: _____

ID# _____ Group# _____

Relationship to Insured" ___ Self ___ Spouse ___ Child ___ Other ___

Secondary Insurance: _____

Insured Name: _____ Date of Birth: _____

ID# _____ Group# _____

Insured Name: _____ Date of Birth: _____

Relationship to Insured: ___ Self ___ Spouse ___ Child ___ Other ___

I hereby assign all medical benefits to which I am entitled to Breckenridge Physical Therapy, in the event they file my insurance on my behalf. I understand that I am financially responsible for all charges including supplies, which are Not covered by my insurance. I hereby authorize and assign a release of all information necessary to secure the payment of benefits. I do hereby consent to treatment by Breckenridge Physical Therapy.

Patient's Signature: _____ **Date:** _____

Parent's Signature (If Minor) _____ **Date:** _____