CONEJO VALLEY PHYSICAL THERAPY CVPT

...BRINGING MOTION TO LIFE!

Patient Name:_____ Birthdate:_____ Sex: M/F

Address: _____ City: _____ State:_____ Zip:_____

Telephone:_____ Social Security #:_____ Driver Lic:_____

Occupation:_____Employer:_____ Work Phone:_____

Address:_____City:_____Cell #: _____

Email Address: _____

Person to Contact in Case of Emergency:

Name: _____ Home phone #:_____

Cell #: _____ Work phone #:_____

Primary Care Physician: _____ Phone #:_____

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

_____

Is your condition? ☐ Work related ☐ Auto related ☐ N/A

Current complaint (how you feel today?)

|_____|

0 1 2 3 4 5 6 7 8 9 10

No pain Unbearable pain

How often are your symptoms present? 0-25% 26-50% 51-75% 76-100%

Have you had X-rays, MRI or CT scan taken? No Yes Date taken:_____

What areas were taken? _____

Please check the following that apply to you:

No	Yes	Condition	No	Yes	Condition
____	____	History of Recent Infection	____	____	Pacemaker/Defibrillator
____	____	Recent Fever	____	____	Pregnant
____	____	HIV/AIDS	____	____	Diabetes
____	____	Carotid artery surgery	____	____	Hypertension
____	____	Recent Stroke	____	____	Dizziness/Fainting
____	____	Thyroid medicine	____	____	Urinary Retention
____	____	Aortic Aneurysm	____	____	Cancer/Tumor
____	____	Osteoporosis	____	____	Recent Trauma
____	____	Abnormal weight gain/loss	____	____	Epilepsy/Seizures
____	____	Visual Disturbances	____	____	History of Low back pain
____	____	Arthritis	____	____	History of Neck pain
____	____	History of Alcohol use	____	____	History of Tobacco use
____	____	Cardiac Edema	____	____	Congestive heart failure
____	____	Acute DVT	____	____	Acute Bronchitis
____	____	Bronchial asthmas	____	____	Reflex Sympathetic Dist.
____	____	Cardiac Arrhythmia	____	____	Paralysis
____	____	Recent surgeries:_____			

I certify that the above information is complete and accurate. If the health information is not accurate, or if I am not eligible to receive health care benefits through my insurance company, I understand that I am liable for all charges for services rendered and I agree to notify Conejo Valley Physical therapy immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that CVPT may need to contact my physician if any health conditions change. Therefore, I give authorization to CVPT to contact my physician if necessary.

Patient Signature:_____ Date: _____