Isla Physical Therapy
Professional Therapy Services

Name: __________________ Date: ______________
Sex: M/F Age: _____ Date of Birth: __/__/__ SSN: ______________
Ethnicity: __Hispanic__White__Black__Asain__American Indian__ Other
Home Phone #: ________ Primary Language: __English__Spanish__Other
Home Address: ______________

Work History

Date Last Worked__/__/__ Receiving Worker Comp Income: __Yes__No
Lawsuit? __Yes__No
For what company did you work for when injured? ________________________
What kind of job did you do? ____
How satisfied were you with your job before injury? ________________________
Do you expect to get totally well? __Yes__ No If yes, after how long? _______
Do you expect to be permanently disabled? __Yes-Totally__Yes-Partially__Not at all
Have you had a previous job injury? __No__Yes: When? __/__/__ What? _________
Going back to Work: __I want to very much __I do not want the same job (next line)
__I am afraid of re-injury: Why? ________________________________
I expect to be able to return to my old job when well: True, or False? Because _____
____
I was fired because of my injury: __True, or __False? I was laid off:__True__False

Injury History

Primary Doctor: ____
How were you injured? ____
____
Date of Injury: __________________
What part(s) of the body was injured? ______________________________
Rate your pain currently: circle a number: *No Pain* 0 1 2 3 4 5 6 7 8 9 10 *The Most Pain*
Medical Tests: __X-Rays __MRI __CT Scan __EMG __Myelogram __EEG
What is your medical diagnosis? ___________________________________
What treatments for your injury have you received?

Medication	__Yes	__No	Helpful __Yes __No		List Medication
Physical Therapy	__Yes	__No	Helpful __Yes __No		____________________
Chiropractic Care	__Yes	__No	Helpful __Yes __No		____________________
Steroid Injection	__Yes	__No	Helpful __Yes __No		____________________
Nerve Block	__Yes	__No	Helpful __Yes __No		
Acupuncture	__Yes	__No	Helpful __Yes __No		
Surgery	__Yes	__No	Helpful __Yes __No		

If Surgery, when? __/__/__ Surgeon: Dr.______________Did what?____________
____
Other treatment __Yes __No Helpful __Yes __No
What percent have you improved since first injured? ___% (or is it worse) __________
What makes your pain worse? ____________________________________
What helps relieve pain? _______________________________________
Do you feel you get adequate emotional support from family & friends? ___________

Isla Physical Therapy

Professional Therapy Service

Date: Fecha			
Name: Nombre de Paciente	First	Middle	Last
Date of Birth: Fecha de Nacimiento	Age: Edad		Sex: M F Sexo
Address: Domicilio Permanente		Phone: ( ) Numero de teléfono	
City: Ciudad	State: Estado	Zip: Código Postal	
Driver's License #: Licencia de Manejar		Social Security: Seguro Social	
Employer's Name and Address: Nombre Y Domicilio de su Empleador		Phone: ( ) Numero de teléfono	
Insurance Company Name: Compañía de seguro	Policy Numero de Póliza	Group #	
Adjuster: Ajustador			
In case of Emergency Notify: En caso de Emergencias Notificar	Address: Domicilio	Phone: ( ) Numero de teléfono	
Pharmacy: Farmacia	Phone: ( ) Numero de teléfono		

If assignment is accepted: Please make payment directly to Isla Physical Therapy.
I realize I am responsible for any charges not covered by this authorization. I authorize the release of medical records and/or information necessary, understanding such disclosure will be made in order to facilitate processing my claim and to ensure continuity of medical care.
For Medicare Patients: I understand that Medicare may not cover specific charges or procedures or consider them medically necessary and that I will be responsible for these charges.
Effective July 1, 2003 a financial limitation of $1,590.00 will be implemented for outpatient Physical Therapy/Occupational Therapy services.

Si acepta el caso: Favor de pagar directamente a Isla Physical Therapy.
Yo reconozco que soy responsable por cualquier costo que no esta cubierto por esta autorización. Autorizo que cualquier información necesaria sea dada comprendiendo que cualquier dato será hecho para facilitar el proceso de me reclamo y asegurar la continuidad de mi cuidado medico.
Para pacientes de Medicare: Comprendo que Medicare no cubre médicamente variaos costas y que yo será responsable por ellos.
A partir del 1 de Julio de 2003 habrá un limite de $1,590.00 por los servicios de terapia Física y Ocupacional.

Signature of Patient or Guardian:
Firma de Paciente o Persona Responsable ______________________ Date:
Fecha ____________

Isla Physical Therapy

AUTHORIZATIONS AND INFORMED CONSENT

AUTHORIZATION TO EVALUATE AND TREAT
I hereby authorize Isla Physical Therapy to evaluate conditions relative to my pain/ injury.

AUTHORIZATION TO RELEASE RECORDS
I authorize Isla Physical Therapy to release evaluations and progress notes to my treating doctor, and to my insurance company.
I authorize Isla Physical Therapy to request and obtain all medical records pertaining to my pain/injury.

CONFIDENTIALITY
I understand that Isla Physical Therapy will respect the confidentiality of my records and that he agrees to not release them to any other party than those listed above without the signed consent except in the case of court subpoena or imminent threat of harm to life or property such as a required be state law.

By signing, I agree to the authorizations above, and show consent to all the above.

________________________ Client Signature

______________ Date Signed