hayashida & associates
physical therapy, inc.

ph 805.685.1755 · fax 805.685.1715

5718 hollister ave suite 105 · goleta ca 93117 · 319 anacapa street · santa barbara ca 93101 · hayashidapt.com

Please fill out completely **Date:**

PATIENT INFORMATION

Patient's Last Name	First	Middle	How would you like to be addressed?

Permanent Street Address	City	State	Zip Code

Primary Phone	Circle One: Cell | Home | Work	Secondary Phone	Circle One: Cell | Home | Work

Date of Birth / /	Age	Social Security Number (billing purposes)

E-mail Address	How would you like to receive appointment reminders? Circle one Email None

Occupation	Employer	Employer Address

Prescribing Physician's Name	How did you hear about our office? ☐ M.D. ☐ Friend ☐ Family ☐ Other:

INSURANCE INFORMATION: PLEASE FILL OUT IF SUBSCRIBER/RESPONSIBLE PARTY IS ANYONE OTHER THAN YOURSELF

Type of Insurance	Subscriber's Name	Subscriber's Date of Birth

Person Responsible for Bill or Parent's name	Responsible Party Address or Parent's address

Phone Number	Student Status	Accident Status	Date of injury	Athletic Injury
	Full-time / Part-time	None / Auto / Work		Claim Form: Yes / No

WORKERS' COMPENSATION ONLY

Workers' Compensation Claim # (If Applicable)	Claim's Adjuster	Adjuster's Phone Number

IN CASE OF EMERGENCY

Contact Name	Relationship to Patient	Phone: Home	Work/Cell (Circle One)

TELL US ABOUT YOUR CURRENT PROBLEM:

Onset (circle one): Gradual / Sudden Onset Date: / /

How did it begin:

Previous Episodes?: Yes / No Number:

Symptoms: ☐ Pain ☐ Numbness/Tingling ☐ Weakness/Instability ☐ Stiffness ☐ Other: _____

Fitness Activities:

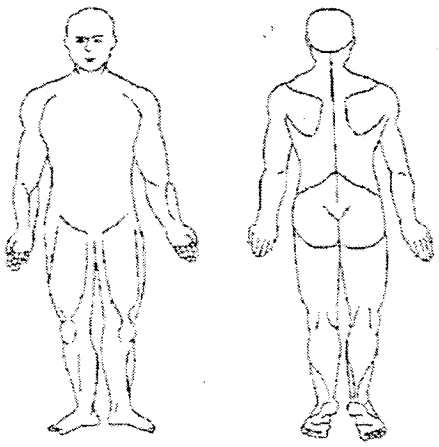
Goals with PT:

Current Pain Level (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



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Please answer all questions regarding your CURRENT problem:

Diagnostic Tests: ☐ None ☐ X-Ray ☐ MRI ☐ Other: _____ Results: _____

Previous Treatments: ☐ PT ☐ Chiro ☐ Meds ☐ Exercise ☐ Other: _____

Activities, Movements, or Positions that INCREASE symptoms:

☐ Sitting/Deskwork ☐ Standing ☐ Walking ☐ Overhead Reaching ☐ Lifting ☐ Bending/Twisting ☐ Sports

☐ Lying Down ☐ Exercise ☐ Other: _____

Activities or Positions that DECREASE symptoms:

☐ Rest ☐ Ice ☐ Heat ☐ Medications ☐ Movement ☐ Sitting ☐ Standing ☐ Lying Down ☐ Exercise ☐ Other: _____

HAVE YOU RECENTLY NOTICED?

Yes No Weight Loss/Gain	Yes No Fatigue	Yes No Chest Pain
Yes No Nausea/Vomiting	Yes No Fever/Chills/Sweats	

HAVE YOU EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS?

Yes No Allergies	Yes No Depression	Yes No Multiple Sclerosis
Yes No Anemia	Yes No Diabetes	Yes No Osteoporosis
Yes No Anxiety	Yes No Dizzy Spells	Yes No Parkinson's
Yes No Arthritis	Yes No Emphysema/Bronchitis	Yes No Rheumatoid Arthritis
Yes No Asthma	Yes No Fractures	Yes No Seizures
Yes No Cancer	Yes No Gallbladder Problems	Yes No Speech Problems
Yes No Cardiac Conditions	Yes No Hepatitis	Yes No Strokes
Yes No Cardiac Pacemaker	Yes No High Blood Pressure	Yes No Thyroid Disease
Yes No Chemical Dependency	Yes No Incontinence	Yes No Tuberculosis
Yes No Circulation Problems	Yes No Kidney Problems	Yes No Vision Problems
Yes No Currently Pregnant	Yes No Metal Implants	Other:

LIST ALL SURGERIES AND/OR INJURIES FOR WHICH YOU HAVE BEEN TREATED

Month/Year:	Month/Year:
Month/Year:	Month/Year:
Month/Year:	Month/Year:

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING FOR ANY CONDITION:

Dosage: Reason:	Dosage: Reason:
Dosage: Reason:	Dosage: Reason:
Dosage: Reason:	Dosage: Reason:

The above information is true to the best of my knowledge. I hereby authorize Hayashida & Associates Physical Therapy, Inc., to release any and all information concerning my care to my insurance company. I further authorize payment directly to Hayashida & Associates Physical Therapy, Inc., and I understand that I am financially responsible for all charges not covered by my insurance carrier. I understand that my insurance carrier Explanation of Benefits is the final determination of payment and patient responsibility regardless of benefit quotes prior to treatment.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

HIPPA Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____ Date _____