Athletes Training For Performance

Patient Information Form

Patient Information

Legal First & Last Name: _____

Date of Birth: _____

Phone Number: _____ **Is Texting Ok?** _____

Enter Yes or No

Email Address: _____

Mailing Address: _____

House Number and Street Name

_____

City, State, Zip code

Emergency Contact Information

First & Last Name: _____ **Relationship:** _____

Primary Phone Number: _____ **Alt Phone Number:** _____

Medical History

Referring Physician: _____ Leave blank if you do not have a prescription for physical therapy

Phone Number: _____

Primary Care Physician: _____

Phone Number: _____

Privacy Policies

Patients must read the supplied privacy policies. By signing below, the patient acknowledges and understands their rights as a patient.

Signature: _____ Date: _____

ATP PHYSICAL THERAPY

Athletes Training For Performance

Reason for Visit

Name: _____ **Date of Birth:** _____

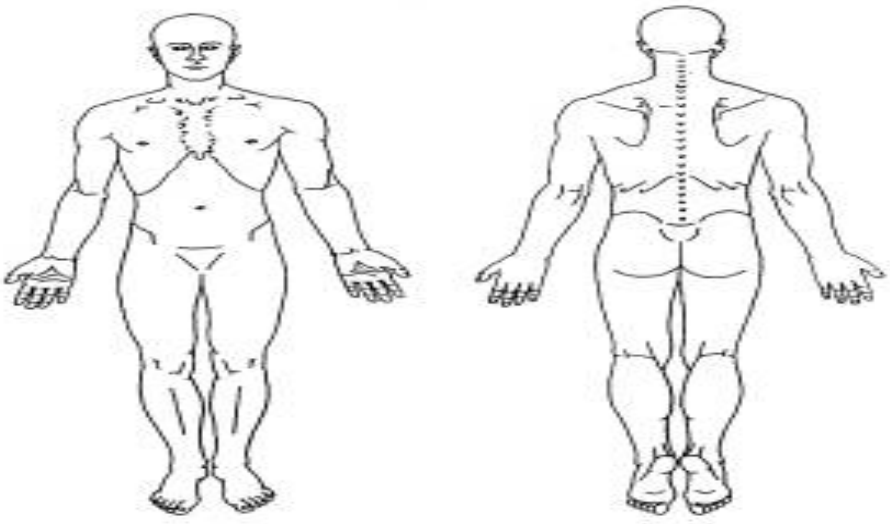
	No	Yes
Do you have a physician referral for today's visit?	☐	☐

Over the past 2 weeks, how would you rate your pain?
On Scale from 0 to 10, where 0 = No Pain to 10 = Extreme Pain

	0	1	2	3	4	5	6	7	8	9	10
Current:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Worst:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Best:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Use the below symbols to mark on this diagram where you feel pain?

Sharp Pain = X Dull/Achy Pain = Z Pins/Needles = ///



Pain Onset: _____ Since: _____

Enter Sudden or Gradual

	No	Yes	If Yes, What?
Have you had any previous treatment:	☐	☐	_____

For example: imaging, injection, physical therapy, chiropracter, etc.

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Medical History Checklist

Name: _____ **Date of Birth:** _____

Medical History	No	Yes	If yes, Explain
Anxiety			
Arthritis			
Asthma			
Cancer			
Concussions			
Congestive heart failure			
COPD			
Coronary artery disease			
Depression			
Diabetes			
Epilepsy			
Headaches			
HIV			
Hypertension			
Joint replacements			
Peripheral neuropathy			

Surgical History	No	Yes	If Yes, List All Surgeries	If Yes, Date of Surgery
Have you had any surgeries:				

Medications	No	Yes	If Yes, List All Medications	If Yes, Reason For Medication
Are you taking medication:				

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Not at all = 0 Several Days = 1 More than Half the Days = 2 Nearly Every Day = 3

1. Little interest or pleasure in doing things: _____
Enter Number 0 to 3

2. Feeling down, depressed or hopeless: _____
Enter Number 0 to 3