CURE PHYSICAL THERAPY PLLC

: 313-584-CURE (2873)
: 313-528-4693
: info@cure-pt.com
: www.cure-pt.com

PATIENT INFORMATION

FIRST NAME	LAST NAME	MIDDLE INITIAL	TODAY'S DATE / /

ADDRESS	CITY	STATE	ZIP

DATE OF BIRTH / /	AGE	Male Female	SSN -- --

HOME PHONE ( ) -	ALTERNATE PHONE ( ) -	EMAIL

How did you hear about us: Doctor Web Search Friend/Family Reference Walk-in Other

Martial Status: Married Single Divorced | Employment: Full-Time Part-Time Not Employed

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	ID #	GROUP #

SUBSCRIBER NAME (If Different)	RELATIONSHIP TO SUBSCRIBER	BIRTH DATE / /

SECONDARY INSURANCE NAME	ID #	GROUP #

SUBSCRIBER NAME (If Different)	RELATIONSHIP TO SUBSCRIBER	BIRTH DATE / /

REFERRING INFORMATION

REFFERRING DOCTOR / PCP	REFFERRING DOCTOR / PCP PHONE # ( ) -

WORK INJURY OR AUTO CLAIM

ATTORNEY'S NAME	___Auto ___Labor & Industry

INSURANCE NAME	PHONE ( ) -	EXT

ADDRESS	CITY	STATE	ZIP

CLAIM #	ACCIDENT DATE / /	CAUSE

EMERGENCY CONTACT

FULL NAME	RELATIONSHIP

HOME PHONE ( ) -	ALTERNATE PHONE ( ) -	EMAIL

I authorize my insurance benefits be paid directly to CURE Physical Therapy. I understand that I am financially responsible for any balance not paid by my insurance company to CURE Physical Therapy, PLLC. I also authorize CURE Physical Therapy to release any information required to process my claims. I agree to comply with the terms & conditions as outlined in this form. I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

_______________________________ PATIENT/GUARDIAN/AUTHORIZED DELEGATE SIGNATURE

_______________________________ DATE (MM/DD/YYYY)

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PAST MEDICAL HISTORY FORM

Patient Name: ______________________ **D.O.B.______________________________**

BLOOD PRESSURE	YES	NO
Hypertension		
Low Blood Pressure		
Normal Blood Pressure		
Heart Disease	**YES**	**NO**
Heart Attack		
Irregular Heartbeat		
Atherosclerotic Disease		
Myocardial Infarction		
Rheumatic Heart Disease		
Heart Murmur		
Do you have a Pacemaker?		
MUSCLE CONDITION	**YES**	**NO**
Carpal Tunnel R/L		
Tennis Elbow R/L		
Back/Neck Problems		
Other		
LUNGS	**YES**	**NO**
Asthma		
Emphysema		
Shortness of Breath		
Other		

JOINT CONDITION	YES	NO
Osteoarthritis		
Rheumatoid Arthritis		
Dislocation		
OTHER CONDITIONS	**YES**	**NO**
Muscular Dystrophy		
Osteoporosis		
Multiple Sclerosis		
Epilepsy		
Gout		
Fibromyalgia		
Diabetes		
Hearing Loss		
Poor Eye Sight		
Fainting		
Polio		
Stroke		
Bladder/Bowel Problems		

Other:

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS		
None	Sitting	Low	Smoking	________	Packs/Day
1-2 x Week	Standing	Medium	Alcohol	________	Drinks/Week
3-4 x Week	Light Labor	High	Coffee/Tea	________	Cups/Day
5+ x Week	Heavy Labor	Extreme	Soda	________	Oz/Day

What types of exercise do you perform? ____

What things cause stress in your life? ____

____ _____________________

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Are you taking any seizure medication? YES NO If Yes, List Name: ____

Are you taking any medication that might affect your lungs, heart, consciousness, or general well being while participating in therapy?

YES NO If Yes, List Name:____

List all surgeries in the past two years (including Dates):

Surgery Name	Date	Surgeon Name	Hospital Name

Are you Pregnant?: YES NO If Yes, How many Weeks?:___________________

Have you had any injuries related to work/Auto Accident? YES NO If Yes, Provide Following Information

Body part	What kind of Injury?	Date of Injury	Treated by?

Have you had Physical Therapy before? YES NO If Yes, Provide Following Information

PT For Which Body part	Date Therapy Started	How many weeks	Treated by?

____ _______________________

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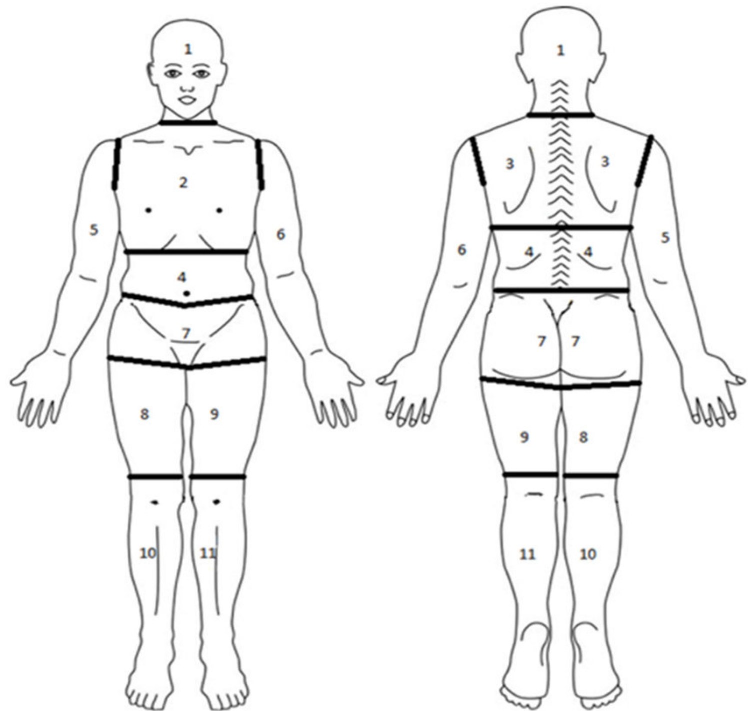
PAIN & SYMPTOM STATUS FORM

Patient Name: ____________________ D.O.B.:____________________________

Ache	Burning	Numbness
AAAAAA	BBBBBB	NNNNNN
AAAA	BBBB	NNNN

Pins & Needles	Stabbing	Other
OOOOOO	//////////	XXXXXXXXX
OOOO	//////	XXXXXX



Chief Complaint and Visual Scale

My Chief Complaint is: ____

Date First Symptom of Problem Occurred on: ____

Pain Increases With: ____

Pain Feels Better With: ____

Please Check on the scale below to indicate Levels of pain:

Current	**No Pain**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Best	**No Pain**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Worst	**No Pain**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Additional Comments:____

____ ______________________

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