

Walter A. Murphy, RPT
1 Pleasant Street, Maynard, Mass. 01754

Dear Patient: Please complete this questionnaire. Your answers will help us determine how we can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank you.

PERSONAL INFORMATION

Name: _____ Date of Birth: ____/____/____ Social Security #: _____

Marital Status: M S W D Spouse's Name: _____ Gender: Male Female

Address: _____ City/Town _____ State: _____ Zip Code: _____

Mailing Address: _____ City/Town _____ State: _____ Zip Code: _____

Home Phone: (____) ____ - ____ Cell Phone: (____) ____ - ____ Email: _____

Work Phone: (____) ____ - ____ Ext. ____ Occupation: _____ Referred By: _____

Employer Name: _____ Address: _____

INSURANCE INFORMATION

Are you covered by Medicare? Yes No If yes, Medicare ID# _____

Are you covered by Masshealth? Yes No If yes, Masshealth ID# _____

Do you have personal health insurance? Yes No Name of Insurer: _____

Insurance ID#: _____ Plan or Group Policy #: _____

Phone #: (____) ____ - ____ Preauthorization Phone#: (____) ____ - ____

Mailing Address: _____ City/Town _____ State: _____ Zip Code: _____

Name of Subscriber: _____ Date of Birth: ____/____/____ Social Security #: _____

Gender: Male Female Relationship to patient: Self Spouse Parent Other Employer/Group Name: _____

Do you have a referral from your primary care physician? Yes No If yes, referral#: _____

Name of referring physician: _____ Phone: (____) ____ - ____

Is this condition the result of an automobile or work related accident? Yes No Date of Accident: ____/____/____

Name of Auto or Worker's Compensation Insurer: _____ Claim#: _____

Mailing Address: _____ City/Town _____ State: _____ Zip Code: _____

Name of Adjuster: _____ Phone: (____) ____ - ____ Ext. ____

Name of Attorney: _____ Phone: (____) ____ - ____ Ext. ____

Mailing Address: _____ City/Town _____ State: _____ Zip Code: _____

If this condition is related to an automobile accident or work related injury, additional information will be required. Please inform the front desk to ask for the additional form to fill out for your injury.

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MEDICAL HISTORY

Have you had previous physical therapy? Yes No When? _____ Where? _____ Why? _____
 Were x-rays taken? _____ Date of last x-ray, including dental: _____ Date of last physical exam _____
 Present reason for contacting this office: Pain, symptoms that are new and acute Pain, symptoms that are chronic in nature
 Preventive Health Care Athletic Injury Work related injury/condition Automobile accident other type of accident
 What is your major complaint? _____

Other complaints _____
 How long have you had this condition? _____ What aggravates your condition? _____
 Have you had this or similar conditions in the past? _____ Explain _____
 Is this condition getting progressively worse? Yes No Constant Comes and goes
 Is this condition interfering with your: work sleep daily routine athletics other, _____
 How long has it been since you really felt good? _____
 Other doctors who have treated this condition: _____
 List surgical operations and years: _____

Women: Are you now, or do you have any reason to believe that you may be pregnant? Yes No

Medications you now take: Pain killers, _____ Anti-inflammatory, _____ muscle relaxants, _____
 Blood pressure meds, _____ Heart Meds., _____ Birth Control pills, _____ Insulin
 Nutritional supplements, _____ Others, _____
 Do you now smoke: Yes No Cigarettes Cigar Pipe For how long? _____
 Sleeping posture: Side Back Stomach Age of mattress, _____ Comfortable? Yes No Unsure
 Do you wear? Orthotics Heel lifts Arch supports Inner soles Sole lifts

Have you ever been in an automobile accident? Yes No If yes, in the past year past five years over 5 years
 Have you had any other type of personal injury or accident? Yes No If yes, describe _____

Please indicate if you are currently experiencing any of the following symptoms:

<input type="checkbox"/>	Neck pain	<input type="checkbox"/>	Mid-Back pain	<input type="checkbox"/>	Low back pain	<input type="checkbox"/>	Sleeping problems
<input type="checkbox"/>	Neck Stiff	<input type="checkbox"/>	Pain between shoulders	<input type="checkbox"/>	Numbness in toes	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Pin & Needles in legs	<input type="checkbox"/>	Irritability
<input type="checkbox"/>	Ear pain	<input type="checkbox"/>	Rib pain	<input type="checkbox"/>	Feet feel cold	<input type="checkbox"/>	Cold sweats
<input type="checkbox"/>	Ears ringing	<input type="checkbox"/>	Shoulder pain	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	Pins & needles in arm	<input type="checkbox"/>	Digestive disorders	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Fever
<input type="checkbox"/>	Arm pain	<input type="checkbox"/>	Stomach upset/nausea	<input type="checkbox"/>	Leg pain	<input type="checkbox"/>	Face flushed
<input type="checkbox"/>	Numbness in fingers	<input type="checkbox"/>	Painful/stiff joints	<input type="checkbox"/>	Hip pain	<input type="checkbox"/>	Loss of smell
<input type="checkbox"/>	Hands feel cold	<input type="checkbox"/>	Painful/stiff muscles	<input type="checkbox"/>	Knee pain	<input type="checkbox"/>	Loss of taste
<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	Muscle weakness	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Head seems too heavy	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Excessive thirst
<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	Excessive/poor appetite
<input type="checkbox"/>	Loss of Balance	<input type="checkbox"/>	Loss of Memory	<input type="checkbox"/>	Blood pressure problems	<input type="checkbox"/>	Menstrual irregularity
<input type="checkbox"/>	Confusion	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Neuritis	<input type="checkbox"/>	Cramping
<input type="checkbox"/>	Light bothers eyes	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Stomach ulcers	<input type="checkbox"/>	Bladder Problems
<input type="checkbox"/>	Tension	<input type="checkbox"/>	Prostate problems	<input type="checkbox"/>	Sexual dysfunction	<input type="checkbox"/>	Other, _____

Please circle the number that best describes your pain.

0 1 2 3 4 5 6 7 8 9 10
 NONE LITTLE MEDIUM MODERATE SEVERE EXTREME

Family History of heart problems, cancer, asthma, allergies, etc.... _____