PHYSICAL THERAPY AND REHABILITATION CENTER
1045 W REDONDO BEACH BLVD., #130 Gardena, CA. 90247 (310) 329-1444

Date:__________________ Attending Dr: __________________
Referred By: ___________________ Dr's Phone #:___________________

Your Name:___________________________ M/F DOB:______________ Age:________
Address:_________________________apt___ City:_______________ State:______ Zip:________
Home Phone:__________________ Work Phone: ________________ Cell Phone:______________
Select "Yes" if the patient has agreed to receive automated phone calls. Select "No" if the patient has declined. YES / NO
SSN:_______-_____-_________ Drivers License:_________________ Email:________________
Date of Injury/accident/symptoms occurred:________________Married/Single/Widowed/Divorced
Area to be treated:____

EMPLOYEMENT INFORMATION
Current Employer:______________________________ Phone #:________________
Address:____________________________ City:________________ State:_________ Zip:_________
Occupational Title:______________________________ How Long Employed?:________________

PRIVATE HEALTH INSURANCE
Insurance Company Name:______________________________ Phone #:________________
Claims Address:______________________ City:________________ State:________ Zip:_________
Name of Insured:______________________________ Insured DOB:________________
Relationship of Insured:___________________ Policy #:___________________ Group#:____________

IN CASE OF EMERGENCY
Relative / Local Friend: ___________________________ Relationship: __________________
Address:____ Phone #:_____________________

Patient Signature:_____________________________________Date:____________________________

If we are treating you due to a work, auto or personal injury please complete the appropriate sections below

WORKERS COMPENSATION INFORMATION (If this is a work related injury complete this section)
Employer at the time of injury: _______________________________ Phone #:________________
Address:_________________________ City:_________________ State:__________ Zip:___________
Workers Comp Insurance Carrier:_____________________________ Phone #:________________
Adjuster:________________________________ Phone #:________________ Ext#:__________
Claim #:_________________________________ WCAB#:____________________________

ATTORNEY INFORMATION
Attorney Name: _______________________________ Phone #:___________________
Address:_________________________ City:_________________ State:________ Zip:_________

PERSONAL INJURY INFORMATION
Insurance Company Name: _______________________________ Phone #:__________________
Contact Person:______________________ Policy #:______________ Group #:________________
Med Pay Coverage: Yes / No If yes, how much?_____________ Name of Defendant:_________________
Defendants Insurance Company:________________________________ Phone #:________________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT TO PAY PROVIDER DIRECTLY

I hereby authorize Gardena Physical Therapy & Rehabilitation Center/ Jana Van Surksum P.T., to furnish information to insurance carriers and/or referring or family physicians concerning my condition and treatments rendered. I hereby authorize payment directly to the above named of the insurance benefits otherwise payable to me. I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes to the above information.

GARDENA
PHYSICAL THERAPY

Functional Assessment

Please **circle 3 or more** of the following activities that cause you the most pain or are the most difficult for you to perform. Please be sure to note your pain level (0-10) with each activity you choose.

Activity			Pain Level 0-10
Sitting:	How long can you sit without pain?	______________	Pain: _____
Standing:	How long can you stand without pain?	______________	Pain: _____
Walking:	How long can you walk without pain? (time or distance)	______________	Pain: _____
Stairs:	Can you use stairs without pain? How many steps?	______________	Pain: _____
Squatting:	Can you squat to pick something up from the floor without pain?	______________	Pain: _____
Dressing:	Do you have any pain when getting dressed / undressed?	______________	Pain: _____
Reaching:	Do you have any pain with reaching overhead?	______________	Pain: _____
Lifting:	Do you have any pain lifting objects? How heavy?	______________	Pain: _____
Housework:	How long can you do housework without pain?	______________	Pain: _____
	Which specific activities bother you?	______________	
Work:	Can you perform your normal work duties without pain?	______________	Pain: _____
	Which duties:	______________	
Other:	Any other activities that bother you?	______________	Pain: _____

Please list any specific goals that you would like to achieve by attending physical therapy

1. ____

2. ____

3. ____

Patient Name:______________________________

GARDENA PHYSICAL THERAPY

Subjective Information

Date:________________ Name:_____________________________ Age:________________________

Date of Injury:_______________ Occupation:________________________

Are you currently working? Yes No Referring Doctor:___________________

Height:_______ Weight:_______ Dominant Hand: (please circle) Right or Left

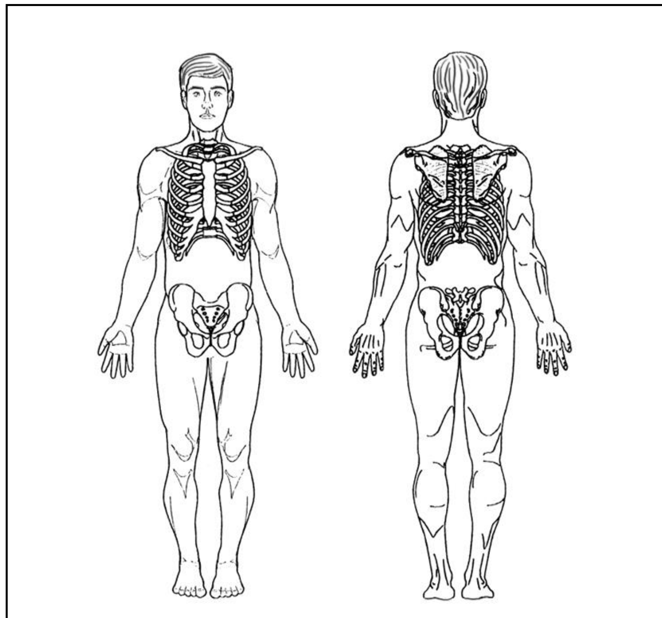
---

Present Injury:

1. Lightly draw in all areas of pain, stiffness, ache, etc., on the drawing to the right.
2. Label the spot of your worst pain.
3. Circle any areas of numbness or tingling.

When did this happen?______________

Where did the injury occur?_________________



Was this due to an injury at home?	_______Yes	_________No
Was this due to an auto accident?	_______Yes	_________No
Is this a post-surgical condition?	_______Yes	_________No
Is this a pregnancy related condition?	_______Yes	_________No
Was this due to a recreational injury?	_______Yes	_________No
Did this happen due to no particular cause?	_______Yes	_________No
Was this due to an injury at work?	_______Yes	_________No
Was this due to a motor vehicle accident while at work?	_______Yes	_________No

Behavior:

Patient Name:___________________________________

What activities or positions ease your symptoms?

_______Doing exercises	_______Sitting
_______Heat or a hot shower	_______Walking
_______Ice	_______Rest
_______Lying on your back with knees up	
_______Lying on side in fetal position	

What activities make your pain worse (mark the worst 2-4 items from list)?

_______Bend w/twist	_______Housework	_______Running
_______Bending	_______Getting in/out of bed	_______Sitting
_______Biting into an apple	_______Getting in/out of car	_______Sports
_______Computer Work	_______Going from sit to stand	_______Squatting
_______Coughing	_______Lifting	_______Turning head
_______Deep breathing	_______Looking down	_______Walking
_______Doing hair	_______Looking up	_______Walking down stairs
_______Dressing	_______Lying down	_______Walking up stairs
_______Driving	_______Lying on stomach	_______Yawning
_______Eating	_______Reaching	

Check one of the following:

Do symptoms _______increase _______decrease or _______stay the same by the end of the day?

When did you first see a Doctor?____________________ Dr's Name:________________________________

Have you had any treatment for this so far? Yes No If yes, please explain:______________________

____

List any other Drs. seen for this problem and what treatment was provided:

1. ____
2. ____

Patient Name:____________________________________

Have you had any of the following for this injury?:

Brace Cast CT Scan EMG Injection MRI Surgery Xray None of the above

What most describes your symptoms: ________Constant _______Intermittent (comes and goes)

If your symptoms are intermittent, how often do you get them? Check one:

_______Daily _______1-2 times/week _______3-5 times/week

How do you describe your symptoms? Check all that apply:

_______Stiffness _______Ache _______Heaviness _______Shooting Pain
_______Numbness/Tingling

On a scale of 0-10, with 10 being the worst pain imaginable and 0 being no pain, where are you on the following scale?

0--------------------2--------------------4--------------------6--------------------8--------------------10

Do you get headaches? _______Yes _______No

If yes, how many times per week? ______________Times/week

Do you feel your symptoms are **decreasing**, **increasing**, or **staying the same**?

History:

What medications are you now taking?:____
____

Are you pregnant? _______Yes _______No _______Possibly

Do you have any metal implants? _______Yes _______No

Do you have or have you ever had, any of the following: (please circle all that apply)

Allergies Asthma Cancer Cardiac Problems Diabetes Osteoperosis

High Blood Pressure Pacemaker Respiratory Problems Seizures Dizziness

Describe **any** previous surgeries, injuries, or illness (***related*** or ***unrelated*** to your present injury)

Please include dates:

1. ____
2. ____

Patient Signature:__________________________________ Date:_________________

Patient Name:_____________________________________