PATIENT INFORMATION			
First Name:	Last Name:		
Address:	City:	State:	Zip:
E-Mail Address:	Home Phone: ( ) -	Birth Date:	Age:
	Secondary Phone: ( ) -	Spouse Name:	
How did you hear about Cornerstone Physical Therapy Associates?			
WORK INFORMATION			
Occupation:	Work Phone: ( ) -	Number of hours worked per day:	
Employer:	Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed		
CARE PROVIDER INFORMATION			
Referring Doctor:	Referring Dr. Phone: ( ) -		
Primary Care Doctor:	Primary Care Dr. Phone: ( ) -		
INSURANCE INFORMATION			
Primary Insurance Provider:			
Subscriber's Name:	Birth Date:		
ID Number:	Group #:		
Patient's Relationship to Subscriber:			
PLEASE FILL OUT THE FOLLOWING IF YOU HAVE A SECONDARY INSURANCE POLICY			
Secondary Insurance Provider:			
Subscriber's Name:	Birth Date:		
ID Number:	Group #:		
Patient's Relationship to Subscriber:			
AUTO OR WORK INJURY INFORMATION *Please complete if this treatment is related to an auto or work injury claim.*			
Insurance Name: ☐ Auto	☐ Labor & Industries		
Adjuster/ Claim Manager:	Phone: ( ) -	Ext:	
Address:	City:	State:	Zip:
Claim #:	Accident Date:	Cause:	
ATTORNEY INFORMATION *Please complete if this treatment is related to an injury or disability claim.*			
Name:	Law Firm:		
Address:	City:	State:	Zip:
EMERGENCY CONTACT INFORMATION			
Name of Emergency Contact:			
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -	

I authorize my insurance benefits be paid directly to Cornerstone Physical Therapy Associates. I understand that I am financially responsible for my balance. I authorize Cornerstone Physical Therapy Associates to release any information required to process my claims.

____ _____________________

PATIENT/ GUARDIAN SIGNATURE DATE

PAST MEDICAL HISTORY FORM **Patient Name:_______________________________**

Please indicate below if you have any history of the following conditions:

BLOOD PRESSURE	YES	NO
Hypertension	☐	☐
Low Blood Pressure	☐	☐
Normal Blood Pressure	☐	☐
HEART DISEASE	**YES**	**NO**
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Stroke (CVA)	☐	☐
Atrial fibrillation (AFIB)	☐	☐
Heart Murmur	☐	☐
Pacemaker or Defibrillator	☐	☐
MUSCLE & JOINT CONDITIONS	**YES**	**NO**
Carpal Tunnel Syndrome	☐	☐
Tennis Elbow Syndrome	☐	☐
Back/Neck Problems	☐	☐
Fracture/Strain/Sprain	☐	☐
LUNGS	**YES**	**NO**
Asthma	☐	☐
Emphysema	☐	☐
COPD	☐	☐
Shortness of Breath	☐	☐

OTHER CONDITIONS	YES	NO
Arthritis	☐	☐
If yes, Rheumatoid or Osteo?		
Diabetes	☐	☐
Cancer	☐	☐
Parkinson's	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy or Seizure	☐	☐
Fibromyalgia	☐	☐
Cerebral Palsy	☐	☐
Vertigo	☐	☐
Depression	☐	☐
Hearing Loss	☐	☐
Vision Issues/ Glaucoma	☐	☐
Hepatitis	☐	☐
Thyroid Issues	☐	☐
Chemical Dependency	☐	☐

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS
☐ None	☐ Sitting	☐ Low	☐ Smoking
☐ 1-2x per week	☐ Standing	☐ Medium	☐ Alcohol
☐ 3-4x per week	☐ Light Labor	☐ High	☐ Coffee/Soda
☐ 5x per week or more	☐ Heavy Labor		

List all medications you are currently taking: ____

____

List all surgeries (and year of surgery):____

____

Have you had any work-related injuries? ____

Have you had any auto-accident injuries? ____

Have you had Physical Therapy, Massage Therapy, or Chiropractic care? __________________________

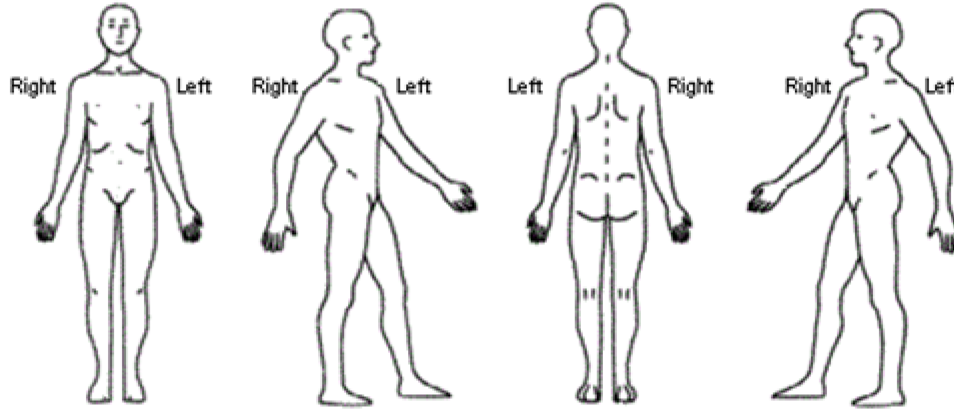
____ ________________

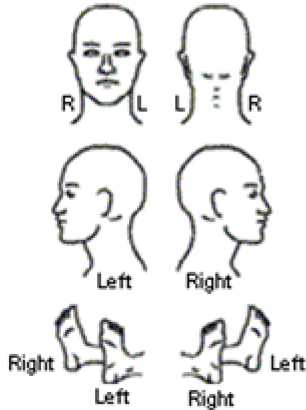
Signature of Patient, Parent, Guardian, or Legal Representative Date

Pain and Symptom Status Report

Name: ________________________________ Date:_____________________

Using the diagram below, circle the area in which you are having pain or complications.





What sensation do you feel in these areas?
(Please Circle)

Ache	Burning
Numbness	Stabbing
Tingling/Tickling	Pins/Needles
Other: ________________________	

How often does this sensation occur:

____

What activities, if any, trigger this sensation :

____

Chief Complaint and Visual Analog Scale
My Chief Complaint: ____
Date of First Occurrence of this Symptom:____
2nd Complaint: ____
3rd Complaint:____
Pain Scale
No Pain 1 2 3 4 5 6 7 8 9 10 Most Severe Pain
Please rate your CURRENT level of pain: _____
What number represents your level of pain on AVERAGE: _____
What number represents your pain at its WORST: _____

Please list any change in medications since your last evaluation: _________________________

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information will be used by this practice, known as Cornerstone Physical Therapy Associates or disclosed to others for the purpose of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

We are providing you with a copy of our Notice of Privacy Practices. We request that you review the notice prior to signing this consent. You may request a restriction on the use or disclosure of your protected health information. If you wish to restrict your disclosure, you should make that request in writing.

This practice, however, may or may not agree to restrict the disclosure of your protected health information. If we agree to your request, the restrictions will be binding. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

You may revoke the consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received will not be affected.

This practice reserves the right to modify the privacy practices outlined in the notice.

SIGNATURE

I have reviewed this consent form and have reviewed the Notice of Privacy Practices. I give my permission to this practice to use and disclose my health information in accordance with it.

____
Name of Patient (Print Clearly)

____
Signature of Patient   Date

____
Signature of Patient Representative

____
Relationship of Patient Representative to Patient