NESTOR PHYSICAL THERAPY LLC

Restoring Quality of Life with Each Range of Motion

Name:	Date of Birth:	Age:
Address:	Soc Sec #:	
Town/City:	State:	Zip:
Home Phone:	Work:	Cell:
Email Address:		
Employer:	Occupation:	
Is this a work related injury: Yes ☐ No ☐	Is this injury due to a motor vehicle accident? Yes ☐ No ☐	
Referred By:	Primary Care Physician:	
Primary Insurance:	Secondary Insurance:	
Insured Person's Name:	If under 18, Name of Parent/Guardian:	
Emergency contact name/relation:	Phone #:	

Chief Complaint:	
Date of injury or Surgery:	How did injury occur?

By signing below,

1) I consent to treatment at Nestor Physical Therapy LLC (or treatment of child if signing as parent/guardian).
2) I authorize Nestor Physical Therapy LLC to release medical information to my insurance and my Physician.
3) I authorize Nestor Physical Therapy LLC to bill and collect payments from my insurance company
4) I agree to accept financial responsibility for the treatment I receive including co-pays and deductibles.
5) I acknowledge receipt of Privacy Practices
6) I acknowledge that I have read and agree to the appointment policy including the **$75** fee for missed appointments or appointments canceled with less than 24 hour notice.
7) I acknowledge the health and personal information above is true to the best of my knowledge.

Signature:_____

Printed Name:_____ Date: _____

Nestor Physical Therapy LLC Patient History

Name: _____Next MD appointment: _____

Describe the history of your present INJURY, ACCIDENT, SURGERY, or CONDITION:

_____

_____

Date of Onset: _____ Could you be Pregnant? ☐ No ☐ Yes

Are you currently receiving any other care/treatment for condition mentioned above? ☐No ☐ Yes. If yes list.
Have you received Physical Therapy in the past for the condition mentioned above? ☐ No ☐ Yes. If so when?
Have you received Physical Therapy services for other conditions/problems during this calendar year? If Yes, Please List.

Do you now have or have you ever had any of the following conditions. PLEASE CIRLCE YES OR NO.

Condition			**Condition**			**Condition**		
Arthritis	YES	NO	Diabetes	YES	NO	Numbness/tingling	YES	NO
Osteoporosis	YES	NO	Anemia	YES	NO	Thyroid Problems	YES	NO
High Blood Pressure	YES	NO	Swelling in Ankles	YES	NO	Headaches	YES	NO
Heart Disease/Attack	YES	NO	Deep Vein Thrombosis (DVT)	YES	NO	Head Injury/concussion	YES	NO
Pacemaker	YES	NO	Seizures/Epilepsy	YES	NO	Hernia	YES	NO
CVA/Stroke	YES	NO	Cancer/Tumor	YES	NO	Kidney/Bladder Dysfunction	YES	NO
Vascular Disease	YES	NO	Recent weight loss or gain	YES	NO	Previous Surgeries	YES	NO
Hypersensitivity to Hot/Cold	YES	NO	HIV/AIDS	YES	NO	Previous Fractures	YES	NO
Asthma	YES	NO	Hepatitis	YES	NO	Metal in body/implants	YES	NO
Shortness of Breath	YES	NO	Tuberculosis	YES	NO	Depression	YES	NO
Chronic Cough	YES	NO	Recent infection	YES	NO	Anxiety	YES	NO
Dizziness/Fainting	YES	NO	Fever/chills	YES	NO	Smoking	YES	NO
Nausea/Vomiting	YES	NO	Fatigue/Weakness	YES	NO	Other (please describe below	YES	NO

If you answered "Yes" on any of the above or have other conditions not listed, please explain and give approximate date(s)
Are you presently taking and Medications? Please list.
Do you have any Allergies? ☐ No ☐ Yes. List all allergies.
Patient/Parent/Guardian Signature: Date:

Pain Diagram and Pain Rating

Name: _____ Date: _____/_____/_____

INSTRUCTIONS: Please use the Daigram below to indicate the symptoms you have expereinced over the past 24 hours. Use the key to indicate type of symptoms.

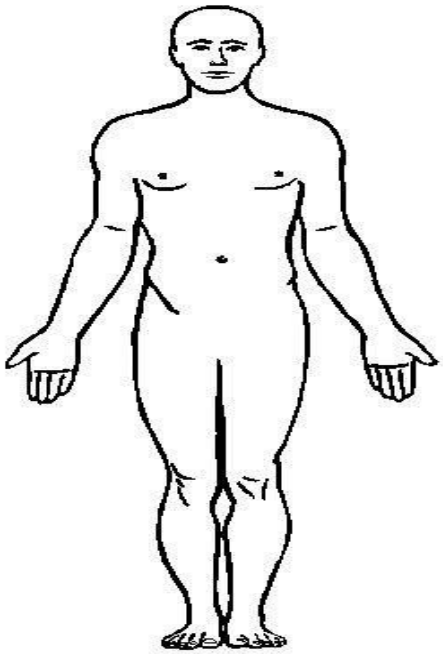
KEY:

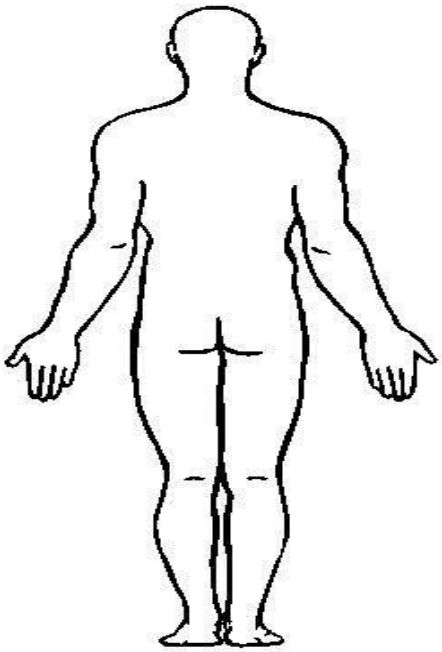
Pins and Needles: 000000000

Stabbing: //////////////////

Burning: XXXXXXXX

Deep Ache: ZZZZZZZ





Please Rate your current level of pain on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10

(No Pain) (Worst imaginable pain)

Please rate your worst level of pain in the last 24 hours on the following scale (check one)

0 1 2 3 4 5 6 7 8 9 10

(No Pain) (Worst imaginable pain)

Please rate your best level of pain in the last 24 hours on the following scale (check one)

0 1 2 3 4 5 6 7 8 9 10

(No Pain) (Worst imaginable pain)