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 hours' 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? Yes ☐ No ☐

Are you currently receiving any other care/treatment for the condition mentioned above? If yes, please list. Yes ☐ No ☐
Have you received Physical Therapy in the past for the condition mentioned above? If yes, please list. Yes ☐ No ☐
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 CIRCLE 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" to any of the above (or have other conditions not listed) please explain & give approximate date(s):
Are you presently taking any Medications? If yes, please list.
Do you have any Allergies? If yes, please list all allergies. Yes ☐ No ☐
Patient or Parent/Guardian Signature: Date:

Pain Diagram and Pain Rating

Name: _____ Date: _____

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

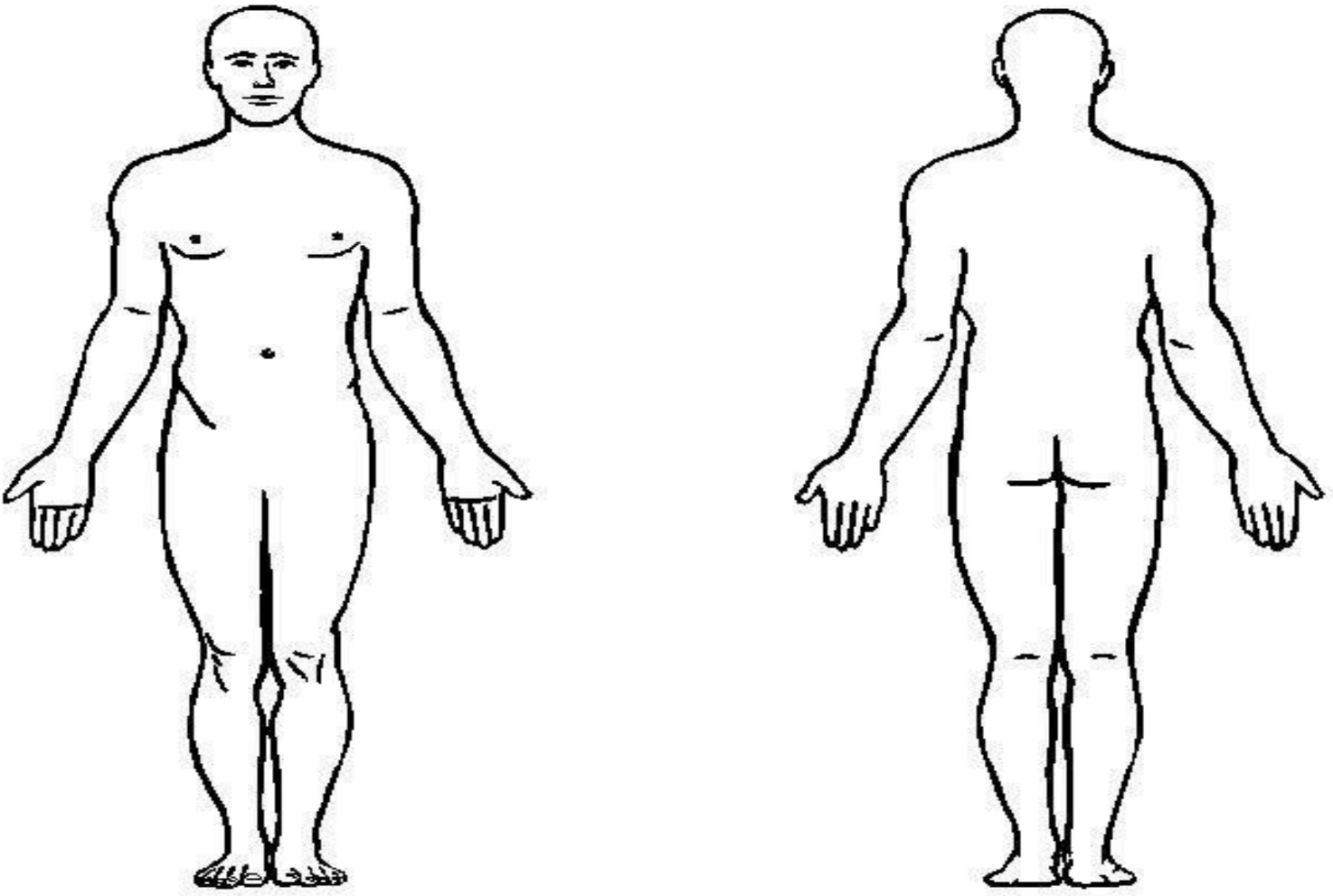
KEY:

Pins and Needles: 000000000

Burning: XXXXXXXXXXXXX

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

Deep Ache: ZZZZZZZZZZZZ



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)