Corona-Temecula Orthopaedic Associates

PHYSICAL THERAPY AND WELLNESS CENTER

PATIENT QUESTIONNAIRE

Please fill out this form **COMPLETELY** using your **LEGAL** name. Do not leave any blanks.

FAMILY PHYSICIAN

(First Name, Last Name)

PATIENT INFORMATION

DATE / /	TO SEE DOCTOR (Name)				
PATIENT'S LEGAL NAME: (Mr./Miss/Mrs./Ms. First, Middle, Last)					
PATIENT'S ADDRESS		CITY		STATE	ZIP
DATE OF BIRTH / /	AGE	SEX ( ) M ( ) F	MARITAL STATUS ( ) M ( ) S ( ) D ( ) W		SOCIAL SECURITY NUMBER XXX– XX –

RESPONSIBLE PARTY / SUBSCRIBER INFORMATION (If different than above)

NAME (Last, First, Middle Initial)	SSN# XXX– XX –
PRIMARY ADDRESS	SECOND CONTACT BILLING ADDRESS (If Applicable)
CITY, STATE, ZIP	CITY, STATE, ZIP
PRIMARY CARE PHYSICIAN	RELATIONSHIP TO PATIENT
PHONE	CITY, STATE, ZIP

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY #	
NAME OF PRIMARY MEMBER INSURED	GROUP #	
ADDRESS OF INSURANCE COMPANY	CO-PAY AMT	DEDUCTIBLE
CITY, STATE, ZIP	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (If Applicable)

NAME OF INSURANCE COMPANY	POLICY #	
NAME OF PRIMARY MEMBER INSURED	GROUP #	
ADDRESS OF INSURANCE COMPANY	CO-PAY AMT	DEDUCTIBLE
CITY, STATE, ZIP	EFFECTIVE DATE	EXPIRATION DATE

REFERRAL SOURCE (How did you hear about our Medical Group)

( ) INTERNET / WEBSITE ( ) FAMILY MEMBER ( ) HOSPITAL ( ) OTHER

AUTHORIZATION OF TREATMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I authorize payment of benefits directly to CORONA-TEMECULA ORTHOPAEDIC ASSOCIATES of the surgical and/or medical benefits if any, otherwise payable to me for their services. I understand that I am financially responsible for any charges not covered by insurance benefits and I am also responsible for any collection or local costs incurred should such costs be necessary for the processing of insurance benefits or medical and/or services rendered. I hereby authorize treatment by CORONA-TEMECULA ORTHOPAEDIC ASSOCIATES.

SIGNATURE OF PATIENT/GUARDIAN ______________________ DATE ____________

SIGNATURE OF INSURED ______________________ DATE ____________

341 Magnolia Avenue, Suite 103 • Corona, California 92879 • Telephone: (951) 284-2827 • Fax: (951) 284-1666

Emile Yacoub, D.P.T., O.C.S., C.S.C.S. — *Director of Physical Therapy and Wellness Center*
Coleen Liagas, M.S.P.T., O.C.S. — *Physical Therapist*
Claire Payken, D.P.T. — *Physical Therapist*
Neilvon Langas. P.T.A. — *Physical Therapist Assistant*
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Medical History and Current Symptoms

GENERAL INFORMATION

Name ______________________ Date ______________________
Name of Referring Physician ______________________ Age: ______________________
Date/Time of Next Doctors Appt: ______________________ Date of Birth ______________________
Hand Dominance: Right / Left ______________________ Foot Dominance: Right / Left
Gender Male / Female
Occupation ______________________
Are you Currently Working Yes / No
Working Status (circle one) Full Duty / Modified Duty / Not Applicable
How did you hear about us? ______________________

ONSET AND CURRENT CONDITION

1. Describe the pain or problem(s) in which you are seeking physical therapy. ______________________
2. Circle all that describe the pain or problem(s).

Sharp	Aching	Clicking	Pulsating	Tightness	Numbness
Burning	Stabbing	Dull	Popping	Throbbing	Pulling
Shooting	Tingling	Soreness	Heavy	Weakness	Deep

3. What was the cause of this problem (how did the injury occur)? ______________________
4. Was the cause of the problem(s) sudden or gradual? ______________________
5. What was the date of injury/onset of your problem(s) (be as specific as possible)? ______ /______ /______
6. Date of surgery (if applicable): ______ /______ /______
7. Have you had this problem before? Yes / No

   If yes,
   1. What treatment was provided? ______________________
   2. How long did your symptoms last? ______________________
   3. Did the problem get better, worse or stay the same? ______________________
   4. Does this problem feel similar to the previous problem? ______________________
8. What activities, positions, or actions increase your symptoms? ______________________
9. What activities, positions or actions decrease your symptoms? ______________________

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10. Place a line between 0 and 10, 10 being the worst imaginable pain, which best describes your pain level.

Currently:

0.............. 1.............. 2.............. 3.............. 4.............. 5..............6..............7.............. 8.............. 9.............. 10
none mild uncomfortable moderate distressing horrible excruciating

At its Best:

0.............. 1.............. 2.............. 3.............. 4.............. 5..............6..............7.............. 8.............. 9.............. 10
none mild uncomfortable moderate distressing horrible excruciating

At its Worst:

0.............. 1.............. 2.............. 3.............. 4.............. 5..............6..............7.............. 8.............. 9.............. 10
none mild uncomfortable moderate distressing horrible excruciating

11. Consistency of your pain or problem (circle one): Constant / Sporadic / Varying
12. Since onset, are your symptoms (circle one): Improving / Stable / Getting worse
13. What are your goals from Physical Therapy? ______________________________
14. What clinical tests have you had within the last year?

	Reason	Date
❑ X-rays	________	________
❑ MRI	________	________
❑ CT Scan	________	________
❑ Nerve ConductionStudy	________	________
❑ EKG	________	________
❑ Angiogram	________	________
❑ Stress Test (Treadmill, Bike, Etc.)	________	________
❑ Biopsy	________	________
❑ Other	________	________

15. Please list **ALL** medications you are currently taking.

Medicaiton	Dose	Frequency
________	________	________
________	________	________
________	________	________
________	________	________
________	________	________
________	________	________

16. Please list **ANY** allergies.

____
____
____

17. Have you had Physical Therapy in the Past? ❑ Yes ❑ No

Date: ______________________________

Injury: ______________________________

Clinic: ______________________________

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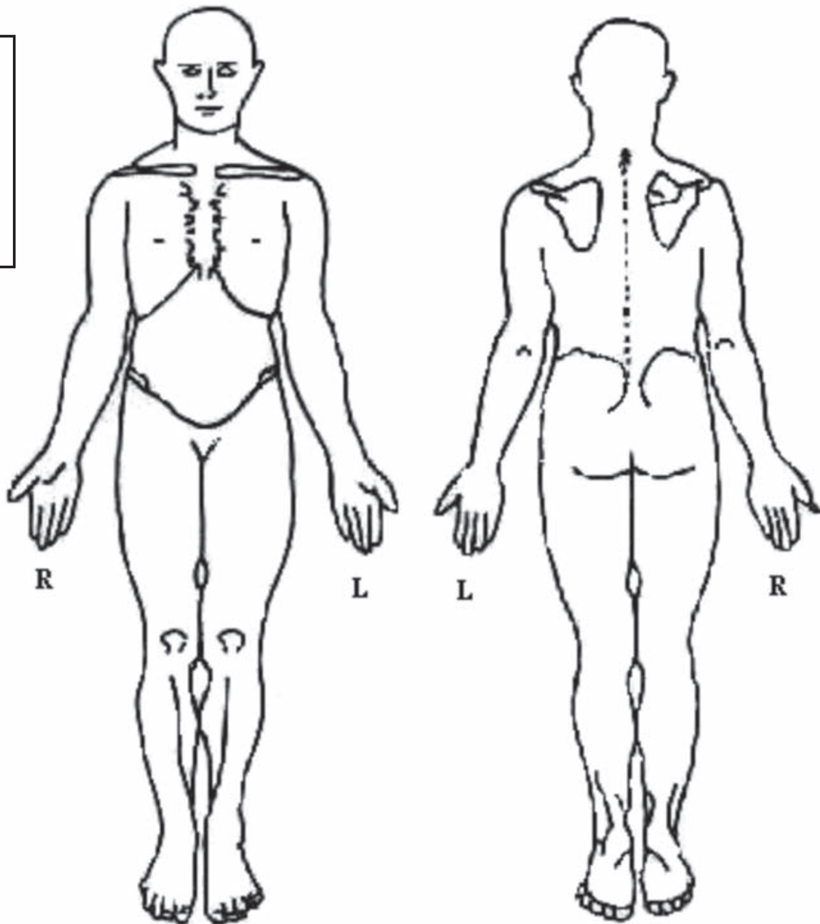
SOCIAL HISTORY

1. Do you smoke or use any form of tobacco? ❑ Yes ❑ No
   If Yes, How many a Day? ___________ For how long? ___________
2. Do you consume alcohol?
   ❑ Never ❑ Daily ❑ Once a Week ❑ Once a Month ❑ Once a Year
3. Describe your exercise history over the last year.
   Example: Biking, 30 minutes per day, 4 days per week
   Activity Type ___________________________
   Minutes/Day ___________________________
   Days/Week ___________________________
4. Highest level of education completed? ___________________________

CURRENT SYMPTOMS & LOCATIONS

Please draw your current symptoms and the location on the body chart utilizing the symbols in the parenthesis. You may use as many of the following descriptions as indicated.



Aching (//////)

Burning (bbbb)

Numbness (xxxx)

Pulling (pppp)

Pins & Needles (= = =)

Stabbing (+++)

Tightness (zzzz)

other (oooo)

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MEDICAL HISTORY

		Patient		Family Member	
		Yes	No	Yes	No
1.	High blood pressure?	❑	❑	❑	❑
2.	Heart or cardiac problems?	❑	❑	❑	❑
3.	Angina/Chest pain?	❑	❑	❑	❑
	(If you answer no to this question, proceed to number 4)				
•	Does your chest pain occur with coughing or breathing?	❑	❑	N/A	
•	Is your chest pain relieved after eating?	❑	❑	N/A	
•	Does you chest pain occur 24-48 hours after a heavy meal or alcohol consumption?	❑	❑	N/A	
•	Does your current chest pain improve in an upright or comfortable position?	❑	❑	N/A	
4.	Currently pregnant?	❑	❑	N/A	
5.	Do you wear a pacemaker?	❑	❑	N/A	
6.	Unexplained weight loss/weight gain?	❑	❑	N/A	
7.	Night Pain?	❑	❑	N/A	
8.	Diabetes?	❑	❑	❑	❑
9.	History of seizures?	❑	❑	❑	❑
10.	Circulatory Problems?	❑	❑	❑	❑
11.	History of strokes?	❑	❑	❑	❑
12.	Osteoporosis?	❑	❑	❑	❑
13.	Osteoarthritis?	❑	❑	❑	❑
14.	Rheumatoid Arthritis?	❑	❑	❑	❑
15.	History of cancer?	❑	❑	❑	❑
16.	Asthma?	❑	❑	❑	❑
17.	Kidney Disease?	❑	❑	❑	❑
18.	Depression?	❑	❑	❑	❑
19.	Panic or anxiety disorder?	❑	❑	❑	❑

Have you had any of the following in the past year?

		Patient	
		Yes	No
1.	Recent episode of fever, chills, or sweats?	❑	❑
2.	Chronic Fatigue?	❑	❑
3.	Change in Appetite?	❑	❑
4.	Recent onset of difficulty retaining your urine or bowel?	❑	❑
5.	Weakness, tingling, numbness, or shooting pain in your lower extremities?	❑	❑
6.	Numbness in the area of your bottom where you would sit on a bicycle seat?	❑	❑
7.	Difficulty with hearing, seeing, speaking or swallowing?	❑	❑
8.	Headaches or migraines?	❑	❑
9.	Loss of consciousness or a history of a head injury?	❑	❑
10.	Diagnosed with an immunosuppressive disorder?	❑	❑
11.	Sexually transmitted disease?	❑	❑
12.	Currently present with an open wound or redness around the wound?	❑	❑
13.	Weakness, numbness, tingling, or shooting pain in your upper extremities?	❑	❑
14.	Recently had a trauma, such as a fall or a motor vehicle accident?	❑	❑
15.	Weakness in your hands or an increased frequency of dropping objects?	❑	❑
16.	Increase of pain with weight bearing?	❑	❑
17.	Currently taking steroids or have had prolonged steroid therapy?	❑	❑
18.	Cortisone injection into one or more joints?	❑	❑

If yes, what joint(s)? ___________________________________

How many shot(s)? ___________________________________

Last injection (date)? ___________________________________

19. Please list any other relevant medical conditions. ____

____

20. Please list all surgeries you have had and the date. ____

____

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Physical Therapy Policies

In order to ensure a safe and positive experience while in physical training, we ask that you please abide by a few guidelines.

- **Co-payments** are due at the time of service. Co-insurance or share of cost will be billed to the insurance first then you will receive a bill for your portion.
- Please be aware that you are responsible for any charges not covered by your insurance company.
- As a safety precaution, children or guests are ***not*** allowed in the gym during your visit. They will be asked to wait in the waiting room.
- Shoes must be worn at all times. ***No sandals or open toe style shoes***.
- No food or beverages allowed in the gym area.
- We do not allow cell phone use in the gym during therapy.
- Please call in advance if you are unable to attend your scheduled appointment or if you are going to be late, so we can adjust our schedule accordingly.
- Please be prepared to expose the body part being treated. Gowns will be provided for your neck or back.

We the staff of Corona-Temecula Orthopaedic Physical Therapy are dedicated to providing you with the best quality care. To achieve this we ask for your assistance. As the patient it is your responsibility to follow the recommendations of your Physical Therapist and Physician. It is necessary that you attend all of your appointments, and be consistent with your home exercise program in order to achieve your goals.

Signature: ______________________________ Date: ____________________
By signing, I declare that I have read and understand the above outlined policy.

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