



**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
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# XX - 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. <i>Director of Physical Therapy and Wellness Center</i>	Coleen Liagas, M.S.P.T., O.C.S. <i>Physical Therapist</i>	Claire Payken, D.P.T. <i>Physical Therapist</i>	Neilvon Langas, P.T.A. <i>Physical Therapist Assistant</i>	Mellissa Rouhe, R.N., M.P.H., C.H.E.S. <i>Health Education Coordinator</i>	Patty Bernabe, C.P.T. <i>Personal Trainer</i>
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*Corona-Temecula Orthopaedic Associates*  
PHYSICAL THERAPY AND WELLNESS CENTER

## *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**

- Describe the pain or problem(s) in which you are seeking physical therapy. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- 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
- What was the cause of this problem (how did the injury occur)? \_\_\_\_\_  
 \_\_\_\_\_
- Was the cause of the problem(s) sudden or gradual? \_\_\_\_\_
- What was the date of injury/onset of your problem(s) (be as specific as possible)? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- Date of surgery (if applicable): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- Have you had this problem before? Yes / No  
 If yes,
  - What treatment was provided? \_\_\_\_\_
  - How long did your symptoms last? \_\_\_\_\_
  - Did the problem get better, worse or stay the same? \_\_\_\_\_
  - Does this problem feel similar to the previous problem? \_\_\_\_\_
- What activities, positions, or actions increase your symptoms? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- 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 Conduction Study
- 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: \_\_\_\_\_



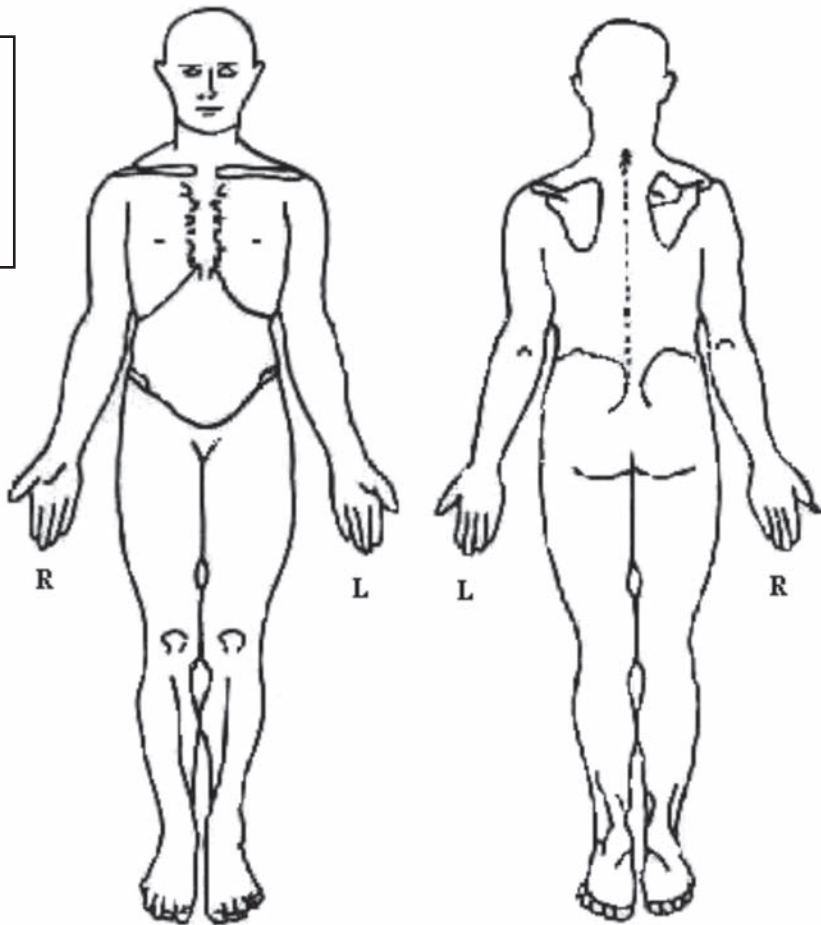
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**SOCIAL HISTORY**

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

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

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

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. \_\_\_\_\_

## ***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.*