BAINBRIDGE CLINIC
840 Madison Ave N.
Ste 102
Bainbridge Island WA, 98110
P: 206•855•0955
F:206•855•0801

DaVinci
PHYSICAL THERAPY

POULSBO CLINIC
19980 10th Ave N
Ste 201
Poulsbo, WA, 98370
P: 360•598•1538
F: 360•598•1541

PATIENT INFORMATION

Name: First _____ MI ____ Last _____ ○Male ○ Female **DOB:**_____

Mailing Address: _____ **City:**_____ **State:** _____ **Zip Code:** _____

Phone: ○Home _____ ○Cell _____ ○Work _____ **SSN:**_____-_____-_____
(Please select the number where we can leave a detailed message during business hours)

Email Address: _____ **Primary M.D.:** _____ **Referring M.D.:** _____○N/A

Insurance: Primary**:** _____ Secondary: _____ **Subscriber:** _____ **DOB:**_____
○Cash Pay (will not be billing insurance)

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ **Relationship:** ○Spouse ○Parent/Guardian ○Child ○Other_____

Phone: ○Home _____ ○Cell _____ ○Work _____
(Please select the number where we can leave a detailed message during business hours)

POLICIES AND AGREEMENTS

CANCELLATION POLICY: If you need to change or cancel your appointment, we are happy to do that for you--provided that you let us know at least 24 hours in advance. However, if you cancel your appointment with **less than 24 hours notice** or fail to show up for your appointment, we will charge you a **$75 fee**.
INITIALS : _____

PRIVACY POLICY: I acknowledge that I have reviewed, received, or been offered the DaVinci Physical Therapy NOTICE OF PRIVACY PROCEDURES

PAYMENT AGREEMENT: I, the undersigned, agree to assign my insurance benefits to be paid directly to DaVinci Physical Therapy for medical services rendered. **I understand that I am financially responsible for all charges, whether paid or not by insurance**. I hereby authorize DaVinci Physical Therapy to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submission. Billing statements are mailed the first of each month. Outstanding balances are due within 30 days.

Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

CURRENT INJURY INFORMATION

Briefly, describe what problem brings you to Physical Therapy today: _____

Have you had similar problems? ▫ Yes ▫ No **Date of injury/onset of symptoms**:_____

Problem is related to: ▫ Work ▫ home ▫ sports ▫ fall ▫ auto accident ▫ Other ▫ Surgery (Date): _____

Does your pain wake you at night? ▫ Yes ▫ No **If yes, can you find a comfortable position and return to sleep?** ▫ Yes ▫ No

Currently, Symptoms are: ▫ Improving ▫ Staying the same ▫ Worsening ▫ Intermittent

Activities that *Increase* Symptoms: _____
_____

Activities that *Decrease* Symptoms: _____
_____

Are you able to work? ▫ Retired ▫ Yes (full duty) ▫ Yes (light duty) ▫ No **If No, last date worked:** _____

Aggravating Factors:

▫ Sitting	▫ Loss of Balance	▫ Dropping Items	▫ Numbness in Groin or Buttocks
▫ Standing	▫ Walking	▫ Lying Down	▫ Numbness in Extremities
▫ Stairs	▫ Squatting	▫ Rotation /Bending	▫ Incontinence

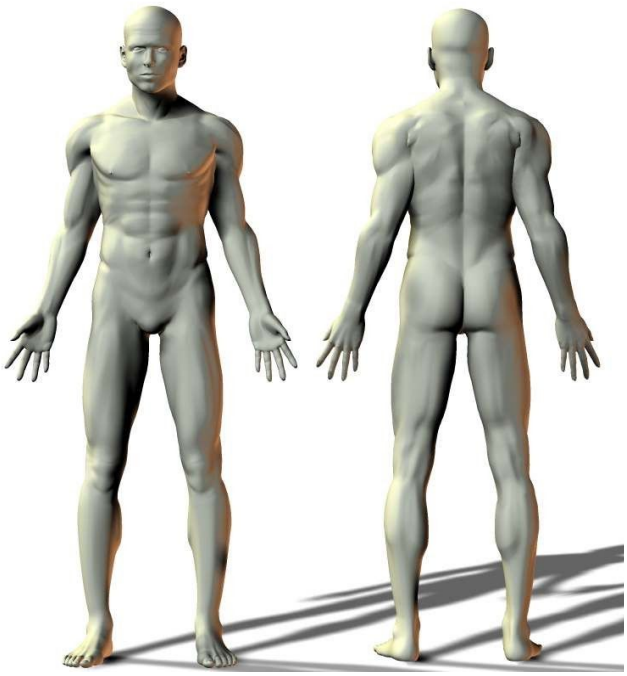
IMAGING

Have you had any medical imaging performed? ▫ Yes ▫ No **If yes, please specify (i.e., X-Ray, MRI, Arthrogram, CT Scan)**

Type of Imaging	Where Performed	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

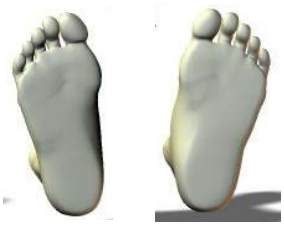
PAIN INDICATOR

Please use the drawings below to indicate where you feel symptoms **RIGHT NOW**.



Use the following Key to indicate different types of symptoms:

Pins/Needles:	000
Burning:	XXX
Sharp:	///
Shooting:	***
Deep Ache:	ZZZ



PAIN SCALE

Using the scales below, please fill in the number that most accurately describes the intensity of your pain:

	No Pain					Moderate Pain					Extreme Pain
	0	1	2	3	4	5	6	7	8	9	10
AT WORST	○	○	○	○	○	○	○	○	○	○	○
CURRENT	○	○	○	○	○	○	○	○	○	○	○
AT BEST	○	○	○	○	○	○	○	○	○	○	○

HEALTH HISTORY

Have you ever been diagnosed or treated for any of the following:

☐ Osteoporosis	☐ Whiplash	☐ Current Infection	☐ Concussion
☐ Osteopenia	☐ Lung Disorders	☐ Huntington's	☐ Hepatitis
☐ Stroke	☐ Tuberculosis	☐ Immunosuppression	☐ Arthritis
☐ Blood Clots	☐ Multiple Sclerosis	☐ Alzheimer's	☐ Nerve Disorders
☐ Heart Disorder	☐ Traumatic Brain Injury	☐ Sprain/Strain	☐ Lupus
☐ High/Low Blood Pressure	☐ Diabetes Type I	☐ Obesity	☐ Fibromyalgia
☐ Cancer	☐ Diabetes Type II	☐ Seizures	☐ Parkinson's Disease

☐ Other: _____

MEDICATIONS

Please list any current medications or supplements:

Name	Purpose
_____	_____
_____	_____
_____	_____
_____	_____

What are your goals and expectations for Therapy? _____

_____

_____