Hamburg Physical Therapy, P.C.

Patient Information

Last Name: _____ First Name: _____ MI: __

Address: _____ City:_____ State:__ Zip:_____

Home Phone: (____) ____-_____ Work Phone: (____) ____-_____ Cell Phone: (____) ____-_____

Email: _____

Date of Birth: _____ Gender: _____ Marital Status: _____

Emergency Contact Information

Last Name: _____ First Name: _____

Relationship:_____ Home Phone: (____) ____-_____

Accident Information

Accident Type: Work Related ___ Auto Accident: ___ Other: (Describe) _____

Employer Information *(Only required with Workers Compensation claim)*

Company Name: _____ Phone: _____

Address: _____ City: _____

Address2: _____ State: _____ Zip: _____

State Accident occurred in: _____

Problem

Problem Description: _____ Date of Injury: _____

Referred By: _____ Last Physician Visit: _____

Primary Insurance

Insurance: _____ Deductible: _____ Subscriber Name: _____

ID: _____ Max Benefit: _____ Relationship: _____

Group # _____ Coinsurance: _____ Date of Birth: _____

Secondary Insurance

Insurance: _____ Deductible: _____ Subscriber Name: _____

ID: _____ Max Benefit: _____ Relationship: _____

Group # _____ Coinsurance: _____ Date of Birth: _____

Tertiary Insurance

Insurance: _____ Deductible: _____ Subscriber Name: _____

ID: _____ Max Benefit: _____ Relationship: _____

Group # _____ Coinsurance: _____ Date of Birth: _____

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the Patient Registration form.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. *(online at www.hamburgpt.com)*
(You have the right to refuse to sign this acknowledgement if you so choose.)

Signature: _____ Date: _____

Pain Diagram and Pain Rating

Name: _____ Date: _____

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.

Please rate your **CURRENT** level of pain on the following scale, (check one).

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Please rate your **WORST** level of pain in the last 24 hours on the following scale, (check one).

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

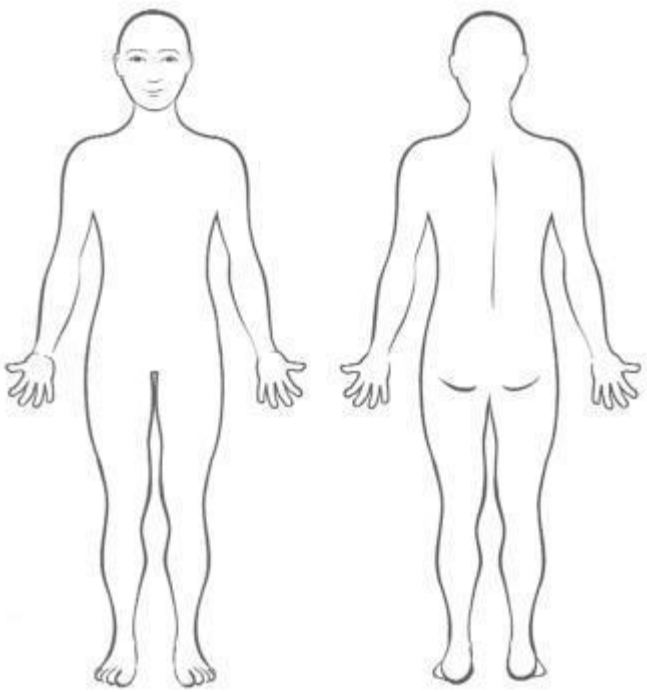
Please rate your **BEST** level of pain in the last 24 hours on the following scale, (check one).

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Mark Your Pain and Symptoms

Pins and Needles = 000000 Stabbing = //////

Burning = XXXXXX Deep Ache = zzzzzzz



Describe your symptoms by checking the appropriate boxes.				
	None	Mild	Moderate	Severe
Throbbing				
Shooting				
Stabbing				
Cramping				
Gnawing				
Hot-Burning				
Aching				
Heavy				
Tender				
Splitting				
Tiring-Exhausting				
Sickening				
Fearful				
Punishing-Cruel				

Medication List for ____

Date: ____

Please list all medications, including all prescriptions, over the counter medications, herbals, vitamins, minerals, and dietary supplements. Include the dosage, frequency and administration method for each medication.

Medication	Dosage	Frequency	Method of Administration
		❒ As Needed ❒ Once Daily ❒ Twice Daily ❒ Three Times Daily ❒ Other	❒ Oral ❒ Sublingual ❒ Topical ❒ Subcutaneous injection ❒ Other
		❒ As Needed ❒ Once Daily ❒ Twice Daily ❒ Three Times Daily ❒ Other	❒ Oral ❒ Sublingual ❒ Topical ❒ Subcutaneous injection ❒ Other
		❒ As Needed ❒ Once Daily ❒ Twice Daily ❒ Three Times Daily ❒ Other	❒ Oral ❒ Sublingual ❒ Topical ❒ Subcutaneous injection ❒ Other
		❒ As Needed ❒ Once Daily ❒ Twice Daily ❒ Three Times Daily ❒ Other	❒ Oral ❒ Sublingual ❒ Topical ❒ Subcutaneous injection ❒ Other
		❒ As Needed ❒ Once Daily ❒ Twice Daily ❒ Three Times Daily ❒ Other	❒ Oral ❒ Sublingual ❒ Topical ❒ Subcutaneous injection ❒ Other
		❒ As Needed ❒ Once Daily ❒ Twice Daily ❒ Three Times Daily ❒ Other	❒ Oral ❒ Sublingual ❒ Topical ❒ Subcutaneous injection ❒ Other