Welcome to our office.

DYNAMIC CORE Physical Therapy

Confidential Patient Case History and Application for Treatment

Please complete ALL parts to this questionnaire. This confidential history will be part of your permanent record. Thank you.

Patient Information:

Patient Name: _____ DOB: _____ Age:_____ Sex: M F

If under the age of 18, Parent / Guardian Name: _____

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

E-Mail: _____Social Sec:_____ Marital Status: S M D W

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

Occupation: _____ Employer: _____

How did you hear about our office? _____

Who referred you to our office? _____

Present Condition:

Reason for THIS visit: _____

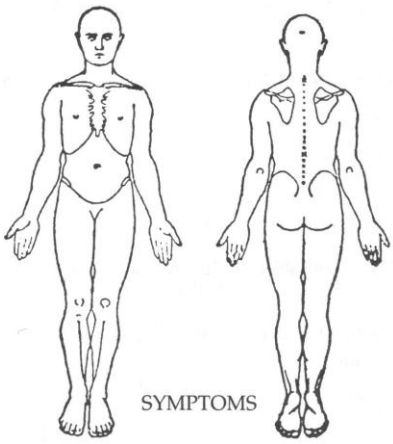
When did your symptoms appear? _____ Is this condition getting progressively worse? Y N

Any other healthcare providers treating you for this? _____

Rate the severity of your pain from 1 (least pain) to 10 (severe pain): _____

Type of symptoms: ☐ Sharp ☐ Shooting ☐ Burning ☐ Dull ☐ Throbbing ☐ Aching ☐ Cramping ☐ Stiffness ☐ Swelling ☐ Numbness ☐ Tingling ☐ Other: _____

Please mark your symptoms on the picture:
"X" = Pain / Tightness / Stiffness **"O"** = Numbness / Tingling



How often do you have this pain? (Please mark all that apply)
☐ Constant ☐ Come and go ☐ Daily
☐ Weekly ☐ Mornings ☐ End of day

Does it interfere with your:
☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities that are painful to perform:
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down

Patient Agreement:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office with be credited to my account upon receipt I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient / Guardian Signature: _____ **Date:** _____