WholePerson Therapeutics LLC

: 203 636 0065
: 203 242 8345

PATIENT INFORMATION FORM

	TODAY'S DATE:		DATE OF BIRTH:	
NAME:	☐ MALE ☐FEMALE	AGE:	☒MARRIED ☐SINGLE ☐WIDOWED ☐DIVORCED ☐ SEPARATED ☐________	
ADDRESS:	CITY:		STATE:	ZIP:
HOME PHONE:	CELL:		FAX:	
SOCIAL SECURITY #:	DRIVER'S LICENSE:	STATE:	EMAIL ADDRESS:	
SPOUSE'S NAME:	AGES OF CHILDREN:		OCCUPATION/JOB TITLE:	
EMPLOYER/BUSINESS NAME:	BUSINESS ADDRESS:			
BUSINESS PHONE:	TYPE OF WORK:			
HOW DID YOU HEAR ABOUT US?				
EMERGENCY CONTACT:			PHONE #:	

INSURANCE				
	ADDRESS:		RELATIONSHIP:	
	WHO IS RESPONSIBLE FOR YOUR BILL?	☐SELF ☐WORKER'S COMP	☐AUTO INSURANCE MEDICARE	☐MEDICAID ☐OTHER (BE SPECIFIC):
	PERSONAL HEALTH INSURANCE CARRIER:		HEALTH ID CARD #:	
	INSURED PERSON'S NAME:		PRIMARY CARE PHYSICIAN:	
	INSURED PERSON'S SOCIAL SECURITY #:		PHARMACY:	

CURRENT HEALTH CONDITION

PLEASE CIRCLE AREAS OF DISCOMFORT

CHIEF COMPLAINT: (WHY ARE YOU HERE TODAY?)

<table>
<tr><th colspan="7">DISCOMFORT CAUSED BY CHIEF COMPLAINT</th></tr>
<tr><td>BODY AREA INVOLVED:</td><td colspan="3">☐CERVICAL (NECK)
☐SPINE (MID-BACK), RIBS, PELVIS (LOW BACK)</td><td colspan="3">☐UPPER EXTREMITY (ARMS, WRIST, HANDS)
☐LOWER EXTREMITY (LEGS, FEET, TOES)</td></tr>
<tr><td>CONDITION:</td><td colspan="3">☐NEW
☐RECURRING</td><td colspan="3">☐EXACERBATION
☐CHRONIC</td></tr>
<tr><td>WHAT CAUSES IT:</td><td>☐AUTO
☐WORK</td><td>☐FALL
☐LIFTING</td><td>☐OVER EXERTION
☐REPETITIVE MOTION</td><td>☐UNKNOWN
☐SLEPT WRONG</td><td>☐SLIP OR FALL
☐NO INJURY</td><td>☐OTHER</td></tr>
<tr><td>SYMPTOMS:</td><td>☐PAIN
☐NUMBNESS</td><td>☐STIFFNESS
☐WEAKNESS</td><td colspan="4"></td></tr>
<tr><td>LOCATION:</td><td>☐LEFT
☐RIGHT</td><td>☐BILATERAL</td><td colspan="4"></td></tr>
<tr><td>QUALITY:</td><td>☐BURNING
☐DIFFUSE</td><td>☐ DULL/ACHING
☐LOCALIZED</td><td>☐SHARP
☐SHOOTING</td><td>☐STABBING
☐THROBBING</td><td>☐TIGHTNESS
☐TINGLING</td><td>☐RADIATING
☐OTHER</td></tr>
</table>

ON A SCALE OF 0-10, (10 BEING THE WORST) RATE YOUR SYMPTOMS	0	1	2	3	4	5	6	7	8	9	10
ON A SCALE OF 0-10, (10 BEING THE WORST) RATE YOUR SYMPTOMS (RESTING):	0	1	2	3	4	5	6	7	8	9	10
ON A SCALE OF 0-10, (10 BEING THE WORST) RATE YOUR SYMPTOMS (WITH ACTIVITY):	0	1	2	3	4	5	6	7	8	9	10

Field	
DURATION: SYMPTOM(S) STARTED:	
SYMPTOM(S) WORSENED:	
SYMPTOM(S) LAST OCCURRED:	
SYMPTOM(S) LAST EPISODE:	
INJURY OCCURRED:	
ACCIDENT OCCURRED:	

<table>
<tr><td>TIMING WORSE IN THE:</td><td colspan="7">☐MORNING ☐AFTERNOON ☐NIGHT ☐W/ACTIVITY ☐CONSTANT ☐INTERMITTENT</td></tr>
<tr><td>ASSOCIATED SIGNS & SYMPTOMS:</td><td colspan="7">☐BLURRED ☐VISION ☐DEPRESSION ☐DIZZINESS
☐HEADACHES ☐IRRITABILITY/MOOD SWING ☐LOCALIZED TINGLING
☐NAUSEA ☐RADIATING ☐RINGING IN EARS
☐SLEEP ☐DISTURBANCE ☐STIFFNESS</td></tr>
<tr><td>QUALITY OF HEADACHES:</td><td colspan="7">☐ DULL ☐ SHARP
☐ THROBBING ☐STABBING
☐AURA ☐NO AURA
☐ RADIATION: ☐LEFT ☐RIGHT ☐BILATERAL
☐ WEAKNESS: ☐LEFT ☐RIGHT ☐BILATERAL</td></tr>
<tr><td>OTHER ASSOC. SIGNS & SYMPTOMS:</td><td colspan="7">☐ACHES ☐COLD LIMB ☐DIZZINESS ☐FATIGUE
☐FEVER ☐HEARTBURN ☐MUSCLE SPASM ☐NAUSEA
☐NUMBNESS ☐PALE BLUISH SKIN ☐PANIC ☐PINS & NEEDLES
☐RUNNY NOSE ☐STIFFNESS ☐SWEATING ☐SWELLING
☐TINGLING ☐VOMITING ☐WEAKNESS</td></tr>
<tr><td>MODIFYING FACTORS – SYMPTOMS BETTER WITH:</td><td colspan="7">☐ACTIVITY ☐BENDING
☐ COLD ☐HEAT
☐MASSAGE ☒ MOVEMENT
☐OTC MEDS ☐RX MEDS
☐REST ☐ STRETCHING
☐SITTING ☐ STANDING
☐TWISTING ☐WALKING
☐ NOTHING HELPS</td></tr>
<tr><td colspan="4">SINCE CONDITION BEGAN, HAS ANYTHING PERMANENTLY HELPED YOU? IF YES, WHAT.</td><td colspan="4">☐YES ☐NO</td></tr>
<tr><td colspan="4">HAS ANYTHING THAT YOU HAVE DONE, THUS FAR, FIXED YOUR PROBLEM, IF YES WHAT</td><td colspan="4">☐YES ☐NO</td></tr>
</table>

EMPLOYMENT							
OCCUPATION:				WORK (HRS/DAY):			
JOB CLASSIFICATION:	☐ SITTING	☐LIGHT	☐ MODERATE	☐ HEAVY LIFTING	LIFTING FREQUENCY:	☐CONSTANT (66-100% DAY) ☐FREQUENT (33-65% DAY)	☐OCCASIONAL (0-32% DAY)
WORK ACTIVITY POSTURES: (HRS/DAY)	☐SITTING ☐STANDING	☐WALKING ☐CLIMBING	☐PUSHING ☐PULLING	☐KNEELING ☐REACHING	☐TWISTING ☐BENDING		
REPETITIVE ACTIVITIES: (HRS/DAY)	☐COMPUTER ☐PHONE	☐MACHINERY ☐HAND TOOLS	☐ASSEMBLY ☐GRASPING				
HOW DOES THIS CONDITION EFFECT JOB PERFORMANCE:	☐MILD PAINFUL (CAN DO) ☐MODERATE PAINFUL (LIMITED)	☐SEVERE (UNABLE TO PERFORM) ☐OTHER (EXPLAIN)					

DAILY ACTIVITIES: ON A SCALE OF 0-10, TO WHAT LEVEL ARE YOU EXPERIENCING SYMPTOMS WHILE PERFORMING THESE ACTIVITIES

ACTIVITY (CHECK APPLICABLE COLUMN)	0 NO EFFECT	1	2	3	4	5	6	7	8	9	10 UNABLE TO DO
BENDING:											
CARE –INFIRM FAMILY:											
CARRYING GROCERIES:											
CHANGE POS.–SIT-STAND:											
CLIMB STAIRS:											
DRIVING:											
EXTENDED COMPUTER USE:											
FEEDING:											
HOUSEHOLD CHORES:											
KNEELING:											
LIFTING:											
PET CARE:											
READING (CONCENTRATION):											
SELF CARE–BATHING:											
SELF CARE–DRESSING:											
SELF CARE–SHAVING:											
SEXUAL ACTIVITIES:											
SLEEP:											
STATIC SITTING:											
STATIC STANDING:											
WALKING:											
YARD WORK:											

BELOW IS A LIST OF DISEASES THAT MAY SEEM UNRELATED TO THE PURPOSE OF YOUR APPOINTMENT. HOWEVER, THESE QUESTIONS MUST BE ANSWERED CAREFULLY AS THE PROBLEMS CAN AFFECT YOUR OVERALL COURSE OF CARE. REVIEW OF SYMPTOMS – PLEASE FILL OUT ALL OF THE SECTIONS, EVEN IF "DENY"

CONSTITUTIONAL: ☐I DENY ANY CONST. ISSUE(S)	☐CHILLS ☐NIGHT SWEATS	☐WEIGHT GAIN ☐WEIGHT LOSS	☐FATIGUE ☐FEVER	☐DAYTIME SOMNOLENCE (DROWSINESS)		
RESPIRATION: ☐I DENY ANY RESPIRATORY ISSUE(S)	☐ASTHMA	☐COUGHING UP BLOOD	☐SPUTUM PRODUCTION	☐COUGH	☐SHORTNESS OF BREATH	☐WHEEZING

CARDIOVASCULAR: ☐I DENY ANY CARDIO. ISSUE(S)	☐ANGINA (CHEST PAIN OR DISCOMFORT) ☐CHEST PAIN ☐CLAUDICATION (LEG PAIN OR ACHINESS)	☐HEART MURMUR ☐HEART PROBLEMS ☐ORTHOPNEA (DIFFICULTY BREATHING WHILE LYING DOWN)	☐PALPITATIONS (IRREGULAR OR FORCEFUL BREATHING OF THE HEART) ☐PAROXYSMAL NOCTURNAL DYSPNEA (WAKING AT NIGHT WITH SHORTNESS OF BREATH)	☐SWELLING OF LEGS ☐ULCERS ☐VARICOSE VEINS		
GASTROINTESTINAL: ☐I DENY ANY GI ISSUE(S)	☐ABDOMINAL PAIN ☐BELCHING ☐CONSTIPATION	☐DIARRHEA ☐HEARTBURN ☐ HEMORRHOIDS	☐INDIGESTION ☐JAUNDICE (YELLOWING OF SKIN)	☐ABNORMAL STOOL COLOR ☐ABNORMAL STOOL CONSISTENCY	☐VOMITING ☐NAUSEA	
ENDOCRINE: ☐I DENY ANY ENDOCRINE ISSUE(S)	☐COLD ☐DIABETES	☐EXCESSIVE APPETITE ☐EXCESSIVE HUNGER	☐EXCESSIVE THIRST ☐FREQUENT URINATION	☐GOITER ☐HAIR LOSS	☐HOT	
SKIN: ☐I DENY ANY SKIN ISSUE(S)	☐CHANGES IN NAIL TEXTURE ☐CHANGES IN SKIN COLOR	☐HAIR GROWTH ☐HAIR LOSS	☐HIVES ☐ ITCHING	☐PARESTHESIA (NUMBNESS, PRICKLING, OR TINGLING)	☐RASH ☐HISTORY OF SKIN DISORDERS	☐SKIN LESIONS /ULCERS ☐VARICOSITIES
NERVOUS SYSTEMS: ☐I DENY ANY NS ISSUE(S)	☐DIZZINESS ☐FACIAL WEAKNESS	☐HEADACHES ☐LIMB WEAKNESS	☐LOSS OF CONSCIOUSNESS ☐LOSS OF MEMORY	☐ NUMBNESS ☐SEIZURES	☐SLEEP DISTURBANCE ☐STRESS	☐STROKES ☐ TREMORS ☐UNSTEADINESS OF GAIT
ALLERGY: ☐I DENY ANY ALLERGY ISSUE(S)	☐ANAPHYLAXIS (HISTORY OF SNEEZING)	☐FOOD INTOLERANCE	☐ITCHING ☐NASAL CONGESTION	☐SNEEZING		

PAST HEALTH HISTORY – PLEASE FILL OUT CAREFULLY AS THESE PROBLEMS CAN AFFECT YOUR OVERALL COURSE OF CARE.

CHILDHOOD ILLNESS: ☐I DENY ANY CHILDHOOD ILLNESS(ES)	☐ADD ☐ ALLERGIES/HAYFEVER ☐ASTHMA ☐ATOPIC DERMATITIS (ECZEMA)	☐BED WETTING ☐CEREBRAL PALSY ☐CHICKEN POX ☐DEPRESSION	☐DIABETES ☐EAR INFECTIONS ☐FETAL DRUG ☐EXPOSURE	☐FOOD ALLERGIES ☐HEADACHES ☐HEPATITIS ☐HIV	☐ MEASLES ☐MUMPS ☐RASH ☐ SCOLIOSIS	☐SEIZURE DISORDER ☐SICKLE CELL ANEMIA ☐SPINA BIFIDA ☐OTHER (PLEASE DESCRIBE)
ADULT ILLNESS:☐I DENY ANY ADULT ILLNESS(ES)	☐ALZHEIMERS ☐ANEMIA ☐ARTHRITIS ☐ASTHMA ☐CANCER ☐CHICKEN BOX ☐ CHRON'S/COLITIS ☐CRPS (RSD) ☐OTHER ____	☐CVA (STROKE) ☐CYSTIC KIDNEY DISEASE ☐DEPRESSION ☐DIABETES (INSULIN) ☐DIABETES (NON INSULIN) ☐EAR INFECTIONS (FREQUENT) ☐EMPHYSEMA ☐EYE PROBLEMS	☐FIBROMYALGIA ☐HEART DISEASE ☐HEPATITIS ☐HIV ☐HYPERTENSION ☐INFLUENZA PNEUMONIA ☐LIVER DISEASE ☐LUNG DISEASE	☐LUPUS ERYTHEMA (DISCOID) ☐LUPUS ERYTHEMA (SYSTEMIC) ☐MULTIPLE SCLEROSIS ☐PARKINSON'S DISEASE ☐PLEURISY ☐PNEUMONIA ☐PSYCHIATRIC PROBLEMS ☐SCOLIOSIS	☐SEIZURE DISORDER ☐SHINGLES ☐STD'S (UNSPECIFIED) ☐SUICIDE ATTEMPT(S) ☐THYROID PROBLEMS ☐VERTIGO ☐PAST HISTORY OF SIMILAR SYMPTOMS TO YOUR CURRENT CONDITION	
SURGERIES:☐I DENY ANY SURGERY (IES)	☐ANGIOPLASTY ☐APPENDECTOMY ☐CAESAREAN SECTION ☐CARDIAC CATHETERIZATION ☐CARPAL TUNNEL REPAIR	☐CORONARY ARTERY BYPASS ☐COSMETIC ☐D & C ☐DENTAL SURGERY ☐GALL BLADDER	☐HEMORRHOIDECTOMY ☐HERNIA REPAIR ☐HYSTERECTOMY ☐JOINT RECONSTRUCTION ☐JOINT REPLACEMENT	☐LAMINECTOMY ☐MASTECTOMY ☐PACEMAKER INSERTION ☐ROTATOR CUFF ☐SPINAL FUSION	☐TONSILLECTOMY ☐OTHER	
INJURIES:☐I DENY ANY INJURY (IES)	☐BACK INJURY	☐FRACTURE ☐DISABILITY	☐INDUSTRIAL ACCIDENT ☐JOINT INJURY	☐MOTOR VEHICLE ACCIDENT ☐MILD/MODERATE SOFT TISSUE INJURY		

	☐BROKEN BONES ☐SEVERE FALL	☐HEAD INJURY	☐SEVERE LACERATION	☐SEVERE SOFT TISSUE INJURY

IMMUNIZATIONS: ☐I DENY ANY IMMUNIZATION(S)	☐DTAP (DIPTHERIA, TETANUS & PERTUSSIS)	☐FLU ☐HEPATITIS A ☐HEPATITIS B	☐HEPATITIS C ☐INFLUENZA ☐IPV (POLIO)	☐MMR (MEASLES, MUMPS, & RUBELLA) ☐PNEUMOCOCCAL ☐PPD (MANTOUX TEST-TB)	☐SMALL POX ☐TB ☐VARIVAX (CHICKEN POX)	☐WHOPPING COUGH (PERTUSSIS)
NON-DRUG ALLERGIES: ☐I DENY ANY NON-DRUG ALLERGIES	☐ANIMALS ☐ ESSENTIAL OILS	☐DAIRY	☐EGGS	☐FOOD COLORING	☒MOLD	☐POLLEN

CURRENT SPECIAL ACCOMMODATIONS TO COMPLETE ADLS:

PRIOR SPECIAL ACCOMMODATIONS REQUIRED TO SUPPORT EMPLOYMENT PRIOR TO EVENT:

AREAS OF DIFFICULTY WITH SELF CARE INCIDENT:

DESCRIBE YOUR RESIDENCE: ☐ HOUSE ☐APARTMENT ☐ STAIRS ☐ NO. OF BATHROOMS_____ ☐ NO. OF BEDROOMS ____

☐ RAMP ☐ KITCHEN ☐ NO. OF RESIDENTS IN HOME____________

WHAT MAKES DISCOMFORT FEEL BETTER/HOW IS DISCOMFORT TREATED:

PREVIOUS TREATMENT

REASON FOR OCCUPATIONAL THERAPY VISIT:

HAVE YOU SEEN A DOCTOR FOR THIS CONDITION?	☐YES IF YES, WHO? (NAME) ☐NO	LOCATION OF OFFICE:	TYPE OF TREATMENT:

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION MEDICATIONS?	☐YES IF YES, PLEASE MARK OR LIST (BE SPECIFIC) ☐NO	☐ALLERGY MEDICATION ☐ANTI-DEPRESSANTS	☐BLOOD PRESSURE MEDS. ☐INSULIN	☐MUSCLE RELAXERS ☐NERVE PILLS	☐PAIN KILLERS ☐OTHER (PLEASE SPECIFY)

DO YOU WEAR ANY OF THE FOLLOWING?	☐HEAL LIFTS ☐INNER SOLES	☐ARCH SUPPORTS ☐ORTHOTICS	PLEASE LIST ANY OTHER CONDITIONS YOU FEEL WE SHOULD KNOW ABOUT – EVEN IF UNRELATED

IMMEDIATE FAMILY

SOCIAL HISTORY

ALCOHOL: ☐NEVER ☐DAILY ☐WEEKLY ☐MONTHLY ☐SOCIAL	SPECIAL DIET: (DESCRIBE)
DRUGS: TYPE, AMOUNT AND FREQUENCY	**TOBACCO**: TYPE, AMOUNT FREQUENCY

PLEAE READ CAREFULLY AND SIGN BELOW

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that WholePerson Therapeutics have been contracted by an entity representing me and/or my concerns. WholePerson will prepare any necessary reports for submission to my medical doctor or entity requesting their service. However, I clearly understand and agree that all services rendered me are charged directly to me, or entity identified prior to provision of services, and that I/entity is responsible for payment. I also understand that if I suspend or terminate treatment or evaluation services requested, any fees for professional services rendered me will be immediately due and payable. I agree that I/entity representing me is responsible for all bills incurred at the office of WholePerson Therapeutics LLC. I hereby authorize the therapist to treat/evaluate my condition as he or she deems appropriate through the use of occupational therapy and physical rehabilitation, and I give authority for these procedures to be performed.

GUARDIAN OR SPOUSE'S SIGNATURE OF AUTHORIZING CARE: (SIGNATURE INDICATES CONSENT TO TREAT)		**DATE:**
PATIENT (PRINT NAME):	**PATIENT'S SIGNATURE:**	**DATE:**