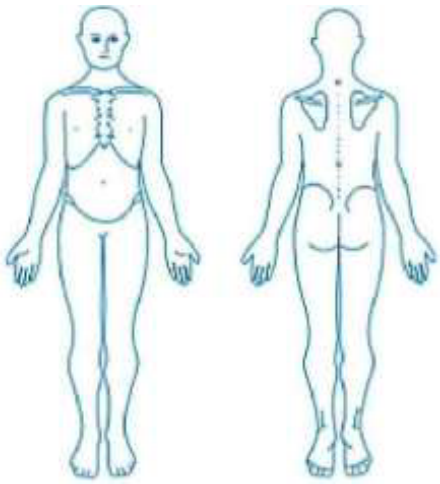
HARAGUCHI
PHYSICAL THERAPY & ORTHOPEDICS



Name: _____
Occupation:_____
Age: _____ **Height:** ____ **ft** ____ **in** **Weight:** _____ **lbs**

Area(s) of Injury:

Using the drawing on the right:

- **Shade** in all areas of symptoms (pain, stiffness, aches, etc…) on the drawing.
- **Label** the spot of the worst pain with a small "**X**"
- **Circle** any areas of numbness or tingling

1. When did your injury occur? __ / __ / __
2. If post-op, when was your surgery? __ / __ / __
   - Type of Surgery: _____
3. Workman's Compensation injury? **Yes / No** if yes, Claim #: _____
4. Pain level (0= No Pain — 10 = Hospitalization):
   - Current Pain Level __ / 10
   - Highest Pain Level __ / 10
   - Lowest Pain Level __ / 10

Medical Questions - (circle Yes/No):

1. **Yes / No —** Do you have a pacemaker?
2. **Yes / No —**Have you experienced significant weight loss recently?
3. **Yes / No —** Have you ever had cancer?
4. **Yes / No—**Have you had multiple cortisone or prednisone injections?
5. **Yes / No** —Are you taking any anti-inflammatory medications?
6. **Yes / No** —Are you taking any muscle relaxants for this problem?
7. **Yes / No —**Are you taking any pain medications for this problem?
8. **Yes / No—**Are you currently taking any other medications?
   a. Please list in on back
9. **Yes / No** Do you have any difficulties with urination, bowel or bladder function?
   a. If YES, please explain

_____

10. Have you had any of the following for this specific problem (circle yes/no):
    - **Yes / No —** CT Scan
    - **Yes / No—** MRI
    - **Yes / No —** X-Ray

Is there any condition that you feel may affect your treatment in any way? (please circle): heart condition, lung condition, osteoporosis, joint replacements, balance deficit, visual impairment, previous surgeries, skin sensitivity, allergies, dizziness, fainting. Please explain:

_____

I acknowledge that the above information I have written is true and accurate to the best of my knowledge. I will notify my therapist of any change in condition.

Patient Signature _____ ***Date***: _____

HARAGUCHI
PHYSICAL THERAPY & ORTHOPEDICS

PATIENT INFORMATION

FIRST _____ LAST _____ MI ___
GENDER: M / F DOB: (MO/DAY/YEAR) ____/____/_____
MARITAL STATUS _____
PHONE (CELL) _____ PHONE (Other)_____
EMAIL _____
ADDRESS _____
CITY_____ ST_____ ZIP _____

INSURANCE INFORMATION

INSURANCE CARRIER: _____SUBSCRIBER ID#_____

EMPLOYER _____
EMPLOYER ADDRESS_____
OCCUPATION _____
WORK PHONE _____ EXT _____
WHO IS YOUR PRIMARY CARE PHYSICIAN? _____

EMERGENCY CONTACT

LAST _____ FIRST _____
RELATIONSHIP _____PHONE (CELL) _____

APPOINTMENT REMINDERS

Select one option below and initial
▫EMAIL REMINDER ____ ▫ TEXT MESSAGE REMINDER: ____ ▫ NO REMINDER ____

Email/Cell Phone # (If different from above):
_____

**Initialing indicates consent for Southland Physical Therapy to provide automatic appointment reminders via the selected method of delivery. I understand that text messaging rates may apply.*

REFERRAL SOURCE

WHO MAY WE THANK FOR REFERRING YOU? _____

▫ Referring MD ▫ Community Event ▫ Return Patient ▫ Friend
▫ Self ▫ Insurance ▫ Online ▫ Walk-in ▫ Social Media

HARAGUCHI
PHYSICAL THERAPY & ORTHOPEDICS

Patient Commitment & Missed Appointment Policy

(Cancellation / No Show / Late - Policy)

Our Commitment to You

At Haraguchi Physical Therapy & Orthopedics, our mission is to demonstrate integrity and compassionate care while providing the utmost quality in physical therapy care so that each individual, their families, and the community may be able to live pain-free and move well.

Your Commitment to Physical Therapy

Every patient comes to physical therapy with unique circumstances and needs. Each individual's treatment is personalized by your therapist by creating a specific plan to meet those goals and needs. In order to meet these goals, it is vital you attend all scheduled appointments.

24-HOUR CANCELLATION POLICY

A 24-hour notice is required for an appointment to be rescheduled. If you need to reschedule, please call our office to arrange for a make-up appointment in the same week of the original appointment.

Please initial:

_____ We ask for a 24 hour notice for any appointment cancellation. If you call to cancel your appointment after this time you will be subject to a $75 fee.

_____ No-show appointments will be charged a $75 fee.

_____ Haraguchi Physical Therapy & Orthopedics reserves the right to cancel your appointment if you are 15 or more minutes late.

I have read and understand the patient financial responsibility & appointment policy and I agree to adhere to its terms.Altering this form in any way will not change the policy as outlined above by Haraguchi Physical Therapy & Orthopedics.

_____ _____ _____

Patient Name (or Responsible Party) Signature Date