MEGAMOTION
PHYSICAL THERAPY

NEW PATIENT NO FAULT INSURANCE INFORMATION

PATIENT NAME:
DATE OF BIRTH:

CONTACT NUMBER:

HOME:
MOBILE:
WORK:

INSURANCE CARRIER:

PRIMARY INSURANCE:	
ID/CLAIM NUMBER:	DATE OF INJURY/ACCIDENT:
CLAIMING ADDRESS:	
CLAIM ADJUSTER:	
ADJUSTER CONTACT NO:	ADJUSTER FAX NO:

DIAGNOSIS:

REASON FOR PHYSICAL THERAPY:	ICD CODES:

EVALUATION NOTES (TO BE FILLED OUT BY PHYSICAL THERAPIST)

What are your goals for physical therapy?

_____

_____

One activity you would love to do that you cannot do now?

_____

Any of the following that are NEW, UNUSUAL or ATYPICAL for you?

☐ **Yes** ☐ **No** Weight loss/gain	☐ **Yes** ☐ **No** Dizziness/Light headedness
☐ **Yes** ☐ **No** Fatigue	☐ **Yes** ☐ **No** Urinary incontinence
☐ **Yes** ☐ **No** Numbness/Tingling	☐ **Yes** ☐ **No** Joint/Muscle swelling
☐ **Yes** ☐ **No** Double/Loss of vision	☐ **Yes** ☐ **No** Difficulty breathing
☐ **Yes** ☐ **No** Regular cough	☐ **Yes** ☐ **No** Pregnant or might be pregnant
☐ **Yes** ☐ **No** Difficulty swallowing	☐ **Yes** ☐ **No** Hearing problems
☐ **Yes** ☐ **No** Problems urinating	☐ **Yes** ☐ **No** Night sweats
☐ **Yes** ☐ **No** Weakness	☐ **Yes** ☐ **No** Problem sleeping