Active Life Therapy Clinic
903 Crenshaw Blvd, #301
Los Angeles, CA 90019
Tel (323) 939-0840
Fax (323) 939-0850

New Patient Form

Patient Name: _____ Phone Number: _____

Address: _____

Date that pain or problem began and brought you here today: _____

Have you had a previous surgery to this area? No Yes If yes, date of surgery: _____

How the injury occurred: _____

Describe your main complaint: _____

What makes your pain/symptoms worse? _____

What makes your pain/symptoms better? _____

Has your condition changed since the date of injury? _____

Does your condition interfere with your sleep? If so, how many times do you wake and how long does it take to go back to sleep?_____

Please rate your current pain level between 0 to 10 (0= no pain, 10=highest possible pain) _____

Are your symptoms: better worse no different in the am?

Are your symptoms: better worse no different in the pm?

List your frequent activities outside of the workplace: _____

_____

Have you had an x-ray, lab test, MRI, bone scan, CT-scan for this injury? _____

_____	_____	_____
Patient Print Name	Patient Signature	Date

Active Life Therapy Clinic
903 Crenshaw Blvd, #301
Los Angeles, CA 90019
Tel (323) 939-0840
Fax (323) 939-0850

Patient Name: _____

PLEASE CIRCLE 'YES' OR 'NO'

Yes No Diabetes
Yes No High Blood Pressure
Yes No Heart Disease
Yes No Cancer or Tumors
Yes No Lung Disease
Yes No Kidney or Liver Problems
Yes No Arthritis or Joint Problems
Yes No Seizures or Nervous Disorders
Yes No Stroke
Yes No Allergies
Yes No Dermatitis (skin problems)
Yes No Eye Problems (glaucoma/cataracts)
Yes No Hernia
Yes No Unusual or frequent headaches
Yes No If female, are you pregnant?
Yes No Any joints replaced or pacemakers?
Yes No Have you taken long-term medication?
Yes No Have you ever taken steroids long term?
Yes No Are you currently taking medication?
Yes No Have you ever had surgery not related to this injury? (PLEASE LIST ON BACK OF SHEET)
Yes No Have you been in a cast, splint, or sling?
Yes No Do you use shoe lifts, corset or braces?
Yes No Are you currently being treated by another PT, Doctor, Chiropractor, Masseuse, or Podiatrist?

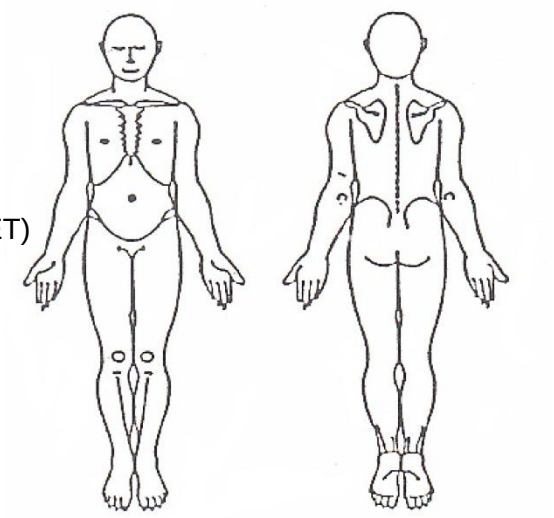
Are there any health problems not mentioned above?

_____

Please list all current medications:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please mark current areas of pain/problems/symptoms:



Patient signature: _____

Active Life Therapy Clinic
903 Crenshaw Blvd, #301
Los Angeles, CA 90019
Tel (323) 939-0840
Fax (323) 939-0850

Active Life Office Policy

The following information will help your rehabilitation experience be more effective and rewarding. Please read the statement below and sign where indicated. Thank you very much.

1. I agree to keep all of the appointments I schedule.

2. If I cannot come to an appointment, I will provide as much notice as possible. I understand that if I do not provide 24-hour notice I may be charged $40 for a missed, broken, or canceled appointment. (Insurance companies do not cover this fee).

3. I understand that if three or more appointments are missed or re-scheduled without notice, consecutively or not, I may be discharged from rehabilitation services. (Active Life will notify your NCM/ADJ/MD).

4. I will notify the front office, and my therapist, at least 24 to 48 hours prior to a scheduled doctor's appointment, so they may send a progress report to my doctor.

5. I understand that my home program exercises and activities are an important part of my therapy process. I will support my progress from therapy by following recommendations daily. I understand that if I have concerns or questions about my home program, I can contact my therapist.

6. I understand my insurance plan may have limitations to the amount of services I can receive and a time frame in which services must be scheduled.

7. I am responsible for all co-pays and insurance percentages, which are due prior to my treatment.

_____	_____	_____
Patient Print Name	Patient Signature	Date