Natalie Imrisek, MSPT, CSCS

PATIENT INFORMATION

Today's Date: _____

Last Name: _____ First Name: _____ MI: ___

Date of Birth: ___/___/_____ Male / Female Marital Status: Single Married Other

Home Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone: _____ Cell Phone: _____

Social Security Number: _____ E-mail address: _____

How did you hear about us? _____

Employment Status: Employed Full-time Student Part-time Student N/A

Employer Name/School Name: _____

Work Address: _____ City: _____ State: _____

Zip Code: _____ Work Phone: _____ Title/Position: _____

REASON FOR TODAY'S VISIT

Is this injury/condition related to: your job an auto accident home accident other

Please indicate the date of your accident/injury: _____

Please indicate the date of your illness: _____

Please describe your injury / accident / illness:

_____

_____

_____

AUTHORIZATION FOR TREATMENT

The undersigned hereby authorizes Natalie Imrisek, MSPT, CSCS to provide physical therapy and other therapeutic treatments deemed necessary for my care. I understand that this type of treatment involves the use of touch for diagnosis and treatment and that my therapist will explain this approach to me.

CANCELLATION AND LATE POLICY

We ask that you arrive on time for your appointments and give 24 hours notice in the event that you need to cancel a scheduled appointment. If 24 hours notice is not given, you will be charged a fee of $75.00. This amount is not covered by insurance.

I understand that if I am late and/or am not able to give 24 hours notice cancellation for my appointments, that the above cancellation policy applies and is not a fee that is covered by insurance.

_____ _____

Signature of Patient or Party Responsible for Bill Date

_____

Printed Name

Natalie Imrisek, MSPT, CSCS

Medical History and Symptom Description

Name: _____ Age: _____ Date:_____

Occupation: _____ Date of Injury or surgery: _____

Job duties or restrictions: _____ not working Part / Full time light / full duty

Describe your injury or symptoms:

_____

_____

Circle today's level of pain Best/No pain Mild Moderate High Severe Unbearable

0 1 2 3 4 5 6 7 8 9 10

I feel BETTER with: _____

WORSE with: _____

Please circle the activities you are having DIFFICULTY or discomfort performing as a result of your injury:

Bending Sitting Standing Steps & Stairs: Up / Down Walking Squatting Kneeling Running or Jumping

Dance specific: plié releve tendu develope passé arabesque turns or jumping

Other: _____

Prior treatments and results:

_____

Diagnostic Testing: X-Ray MRI CT Scan EMG NCV Other: _____

Results:

_____

Medical History: Please circle ALL that apply

Arthritis/DDD/DJD	Asthma	Balance deficits/vertigo	Blood Pressure: Low/High	Blood Disorders
Cancer/Tumor	Diabetes	Dizziness	Fainting	
Fractures: (Please list) 1. _____		2. _____	Heart Disease/Circulatory	Headaches
Incontinence	Kidney disease	Liver disease	Lung/Pulmonary disease	Respiratory
Night time pain	Osteoporosis	Pregnancy	Psychological: (List)_____	
Recent Illness: (please list) 1. _____		2. _____	Seizures	Smoking
Stroke/brain injury	Weight gain/loss			

Other: _____

List pertinent surgeries or medical procedures:

_____

_____

List pertinent MEDICATIONS:

_____

I understand the above information represents my health and symptoms. It is accurate to the best of my knowledge.

I understand that this information will be used to provide a personalized therapy and exercise program for me.

Signatures:

Patient / Guardian: _____

Therapist: _____