HAYASHIDA PHYSICAL THERAPY

ph 805.898.1907 · fax 805.687.8121

319 anacapa street · santa barbara ca 93101 · 5718 hollister ave. ste 105 · goleta ca 93117 · hayashidapt.com

Please fill out completely

Date:

PATIENT INFORMATION

Patient's Last Name	First	Middle	How would you like to be addressed?

Permanent Street Address	City	State	Zip Code

Primary Phone	Circle One: Cell | Home | Work	Secondary Phone	Circle One: Cell | Home | Work

Date of Birth / /	Age	Social Security Number (billing purposes)

E-mail Address	How would you like to receive appointment reminders? Circle one Email None

Occupation	Employer	Employer Address

Prescribing Physician's Name	How did you hear about our office? ☐ M.D. ☐ Friend ☐ Family ☐ Other:

INSURANCE INFORMATION

Type of Insurance	Subscriber's Name	Subscriber's Date of Birth

Person Responsible for Bill or Parent's name	Responsible Party Address or Parent's address

Phone Number	Student Status Full-time / Part-time	Accident Status None / Auto / Work	Date of injury	Athletic Injury Claim Form: Yes / No

WORKERS' COMPENSATION ONLY

Workers' Compensation Claim # (If Applicable)	Claim's Adjuster	Adjuster's Phone Number

IN CASE OF EMERGENCY

Contact Name	Relationship to Patient	Phone: Home	Work/Cell (Circle One)

TELL US ABOUT YOUR CURRENT PROBLEM:

Onset (circle one): Gradual / Sudden Onset Date: / /

How did it begin:

Previous Episodes?: Yes / No Number:

Symptoms: ☐ Pain ☐ Numbness/Tingling ☐ Weakness/Instability ☐ Stiffness ☐ Other:

Fitness Activities:

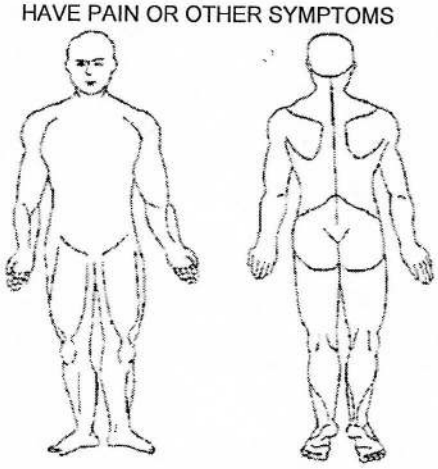
Goals with PT:

Current Pain Level (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



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Please answer all questions regarding your CURRENT problem:

Diagnostic Tests: ☐ None ☐ X-Ray ☐ MRI ☐ Other: _____ Results: _____

Previous Treatments: ☐ PT ☐ Chiro ☐ Meds ☐ Exercise ☐ Other: _____

Activities, Movements, or Positions that INCREASE symptoms:

☐ Sitting/Deskwork ☐ Standing ☐ Walking ☐ Overhead Reaching ☐ Lifting ☐ Bending/Twisting ☐ Sports

☐ Lying Down ☐ Exercise ☐ Other: _____

Activities or Positions that DECREASE symptoms:

☐ Rest ☐ Ice ☐ Heat ☐ Medications ☐ Movement ☐ Sitting ☐ Standing ☐ Lying Down ☐ Exercise ☐ Other: _____

HAVE YOU RECENTLY NOTICED?

Yes No Weight Loss/Gain	Yes No Fatigue	Yes No Chest Pain
Yes No Nausea/Vomiting	Yes No Fever/Chills/Sweats	

HAVE YOU EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS?

Yes No Allergies	Yes No Depression	Yes No Multiple Sclerosis
Yes No Anemia	Yes No Diabetes	Yes No Osteoporosis
Yes No Anxiety	Yes No Dizzy Spells	Yes No Parkinson's
Yes No Arthritis	Yes No Emphysema/Bronchitis	Yes No Rheumatoid Arthritis
Yes No Asthma	Yes No Fractures	Yes No Seizures
Yes No Cancer	Yes No Gallbladder Problems	Yes No Speech Problems
Yes No Cardiac Conditions	Yes No Hepatitis	Yes No Strokes
Yes No Cardiac Pacemaker	Yes No High Blood Pressure	Yes No Thyroid Disease
Yes No Chemical Dependency	Yes No Incontinence	Yes No Tuberculosis
Yes No Circulation Problems	Yes No Kidney Problems	Yes No Vision Problems
Yes No Currently Pregnant	Yes No Metal Implants	Other:

LIST ALL SURGERIES AND/OR INJURIES FOR WHICH YOU HAVE BEEN TREATED

Month/Year:	Month/Year:
Month/Year:	Month/Year:
Month/Year:	Month/Year:

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING FOR ANY CONDITION:

Dosage: Reason:	Dosage: Reason:
Dosage: Reason:	Dosage: Reason:
Dosage: Reason:	Dosage: Reason:

The above information is true to the best of my knowledge. I hereby authorize Hayashida & Associates Physical Therapy, Inc., to release any and all information concerning my care to my insurance company. I further authorize payment directly to Hayashida & Associates Physical Therapy, Inc., and I understand that I am financially responsible for all charges not covered by my insurance carrier. I understand that my insurance carrier Explanation of Benefits is the final determination of payment and patient responsibility regardless of benefit quotes given.

X _____

PATIENT/GUARDIAN SIGNATURE **DATE**

HIPAA Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____ Date _____

HAYASHIDA
PHYSICAL
THERAPY

319 Anacapa Street • Santa Barbara, CA 93101 • 805 898 1907 • 805 687 8121 fax
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HayashidaPT.com

Thank you for choosing Hayashida Physical Therapy. We are taking protective measures to ensure that our patients and staff remain healthy and safe as we continue to serve our community. Please answer the following questions and return it to the front desk before being seen by your Physical Therapist:

A. Have **you or anyone in your household** been experiencing a fever, cough, shortness of breath, loss of taste or smell or stomach upset in the last 14 days?

Please circle one:

Yes or No

B. Have you been in close contact with anyone with Covid-19 in the last 14 days?

Please circle one:

Yes or No

Please adhere to the following new procedures:

1. Per the advisory of Santa Barbara County officials please arrive at our office wearing a protective face mask. You will be required to wear a mask while in our office.

2. Once entering the building please wash your hands thoroughly with soap and water. There will also be hand sanitizer available throughout the clinic.

3. If you arrive early please wait in your car until 5 minutes prior to your appointment time. To minimize the number of people in our office, we ask for patients to come to their appointment alone. All spouses/companions, and drivers need to wait in their car until your appointment is over.

4. Please check-in at the front desk and pay your co-pay before your appointment.

5. Your therapist will greet you at the front and take your temperature before treatment will be rendered.

6. Once your appointment is over, please call our office from your car and we will schedule your follow-up appointments.

Your safety and the safety of our staff is our highest priority. We will turn away any patients refusing to comply with these changes. While we are in the business of service, your safety and health during this time supersedes convenience. Thank you for your cooperation.

Name:_____ Date:_____

Signature:_____