PATIENT GENERAL INFORMATION

Patient name: *(First, Middle, Last)* ____

Preferred name: *(optional)* ______________________ **Date of birth:** _______/_______/_______
month day year

Hand dominance: LEFT / RIGHT / AMBIDEXTROUS

Any recent falls? YES / NO **If "Yes", were you injured?** YES / NO

Work status: RETIRED / STAY AT HOME / EMPLOYED - REGULAR DUTY / EMPLOYED - LIGHT DUTY / UNEMPLOYED

If "Employed": **Occupation / Title:** ______________________ **Work type:** PHYSICAL / SEDENTARY (SEATED)

Describe any physical requirements for your job / homemaking:______________________________________

Do you use adaptive aides or other durable medical equipment to assist in performing daily living tasks? YES / NO

If "Yes", please list:____

Do you live alone? YES / NO **Do you exercise regularly?** YES / NO

Do you smoke tobacco? YES / NO / QUIT **Do you chew tobacco?** YES / NO / QUIT

Do you drink alcohol? YES / NO **Do you use medical marijuana**? YES / NO

Medications: ____

Is this injury related to an accident? Yes / No **If "Yes",** Work Related / Auto Accident / Other:_____________

If "Work Related", Employer: __________________________________

Do you have previous history of (check all that apply):

☐ HIGH BLOOD PRESSURE	☐ HEART CONDITION	☐ DIABETES	☐ CANCER
☐ HEPATITIS B	☐ WEIGHT LOSS	☐ INFECTION	☐ HIV
☐ SEIZURES	☐ DEPRESSION / ANXIETY	☐ FEVER & CHILLS	☐ OTHER: _________________

I UNDERSTAND

- **THERAPY INVOLVES SOME RISKS AND HAZARDS, MOST COMMONLY INCLUDING: SORENESS, REDNESS OF SKIN, BRUISING SWELLING AND PAIN.**
- **THERAPY INVOLVES PATIENT TO PROVIDER PERSON-TO-PERSON CONTACT IN A PROFESSIONAL AND MEDICALLY NECESSARY MANNER.**
- **I MAY SEEK TREATMENT FROM ANY THERAPY PROVIDER/FACILITY THAT I CHOOSE**

I AUTHORIZE AND REQUEST TOCA AND ITS DIVISIONS TO:

- **PERFORM DIAGNOSTIC ASSESSMENTS, EXAMINATIONS, PROCEDURES AND TREATMENTS AS MAY BE TO ASSESS AND TREAT MY CONDITION OR INJURY**
- **RELEASE MY MEDICAL RECORDS TO ANY OTHER PROVIDER OR MEDICAL FACILITIES DIRECTLY INVOLVED IN MY CARE AND FOR THE PURPOSE OF ADMINISTERING CLAIMS AND TO OBTAIN MEDICATION HISTORY FOR THE PURPOSE OF TREATMENT.**
- **ASSIGN PAYMENT OF MY MEDICAL BENEFITS TO TOCA.**
- **RELEASE INFORMATION REGARDING MY CONDITION AND MY ABILITY TO RETURN TO NORMAL ACTIVITY AND/OR WORK TO MY INSURANCE COMPANY/EMPLOYER/LAWYER OR THEIR REPRESENTATIVE**

PATIENT / PARENT / GUARDIAN SIGNATURE: _________________________________ **TODAY'S DATE:** _____/_____/_____
month day year

PID:______________

PATIENT CONCERN INFORMATION

Patient name: *(First, Middle, Last)*: ____ **Date:**_______________

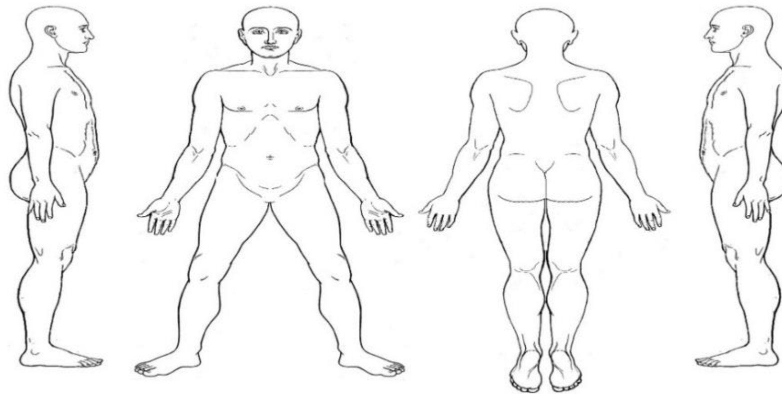
Date of onset / injury: ________________ **Are these new symptoms?** YES / NO

How did this occur? ____

Surgical procedure and date: (if applicable): ____

Side of the body affected: LEFT / RIGHT / BOTH

INDICATE ON THE DRAWING BELOW WHERE YOU HAVE SYMPTOMS



Pain frequency: RARE / SOMETIMES / OFTEN / ALWAYS

Pain scale: *(circle)* 0 1 2 3 4 5 6 7 8 9 10

none moderate severe

Associated symptoms: CATCHING / POPPING / LOCKING / GRINDING / SWELLING / STIFFNESS / INSTABILITY / WEAKNESS / TINGLING / NIGHT PAIN / NUMBNESS/ ACHING / THROBBING / SHARP PAIN / DULL PAIN / BURNING / OTHER: __________________________

Are your symptoms currently: IMPROVING / WORSENING / SAME

What makes it better? ____

What makes it worse? ____

Is this affecting your sleep? YES / NO

How is this affecting you? Please list below up to 3 daily living activities / hobbies that you are unable to do or have difficulty doing because of your symptom(s):

1. ____
2. ____
3. ____

Prior treatment for this problem: ____

What type of images or tests you've had for this problem? ____

What are your personal goal(s) for therapy?____

PROVIDER SIGNATURE: ____________________________________ **TODAY'S DATE:** ______/______/______

month day year

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