Atrium Physical Therapy
Client Information

Patient Name _____ Birth Date: _____

Phone Number: _____ May we send text messages? ***Y*** ***N*** Voice mail messages? **Y** **N**

Email: _____

Emergency contact: Name: _____ Telephone: _____

Relationship to patient: _____

Do you have Advance Directives? ***Y*** ***N*** If so, please provide us with a copy for our file.

Referring doctor:_____

Date of last doctor's appointment:_____ Date and time of next appointment: _____

Have you had any diagnostic studies or tests done for this current problem?

☐ CT scan ☐ MRI ☐ Other _____

Date and Place test: _____

Date and Place test: _____

Why did you choose to come to us? Check all that apply.

☐ Internet ☐ I am a past patient ☐ insurance provider list ☐ Location ☐ Phone Book
☐ Doctor ☐ Friend ☐ Other _____

If doctor or friend whom can we thank? _____

Medicare Only
Are you currently, or have you recently, received care from a home health agency? ***Y*** ***N***
If you are currently receiving Home Health services, speak to the front desk staff.

Workers Comp only
Employer Name:_____ Telephone: _____
Date of Injury: _____

Authorization to Release Information
I authorize Atrium Physical Therapy, Inc. to release any information (current and/or past medical information, billing, appointments, etc.) about myself to the following:

_____I do not want information released to anyone

_____ OK to release information to Emergency Contact above (please initial)

Name:_____Relationship:_____
Please Print

Name:_____Relationship:_____
Please Print

Name:_____Relationship:_____
Please Print

Signature:_____

Office Use Only: Initials of receipt:_____Date:_____

Pulmonary Rehabilitation Client Information

• **Lung disease History: Please describe your history of lung disease or difficulty breathing.**

• **Check the activities you cannot perform due to your lung problem.**

___Sitting
___Lying down
___Standing
___Bending
___Walking
___Walking up/down steps

___ Lifting
___Reaching overhead
___Reaching into back pocket
___Fastening bra
___Putting on pants, shoes, socks

___Mopping
___Vacuuming
___Driving
___Sleeping
___Shampooing
___ Bedmaking

• **Use this shortness of breath scale to answer the following questions:**

SCALE: 0 = NONE 1 = MINIMAL 2 = MODERATE 3 = GREAT 4 = UNABLE

To what degree do you get short of breath during the following activities?

___ at rest?
___ eating?
___ dressing
___ shopping
___ walking your own pace on level surface
___ walking with others your age
___ climbing stairs? How many stairs? ___
___ simple personal care
___ picking up/straightening
___ laundry
___ taking full bath/Shower
___ sweeping/Vacuuming
___ cooking/doing dishes
___ walking one block
___ walking up a slight hill

Pulmonary Rehabilitation Client Information

• **Activity/exercise History:**

Yes No I currently do purposeful walking _____ days a week for _____ minutes.

Yes No I do calisthenics _____ days/week.

Yes No I do not have a purposeful exercise program.

• **The following things limit my ability to remain active:**

_____Shortness of breath _____Lightheadedness (specify):

_____Fatigue _____Joint problems

• **Pulmonary hospitalizations: Number in past year:**

_____ None _____ Treadmill _____ Pool

_____ Stationary bicycle _____Stair-stepper _____ Weights

_____ Other:

• **Pulmonary Hospitalizations:**

Number in past year _____ Number in previous year: _____

Signature:_____ Date:_____

Office Use only: Initials of receipt:_____Date:_____