Date: ______________________________

Name: ____ M__________F __________
Last First M.I.

Address:______________________________________City:___________________St:______Zip: _____________

Birthdate:__________________Age: _______

Marital Status: (mark one) Single___Married _Divorced_ Widowed_ Student___

Home Phone:______________________Work:_______________________Cell: __________________________

Email Address:__________________________________

Employer:____Occupation: ________________________________

Primary Care Physician: ____

Referred by: ____

In case of emergency, please list a contact name: ____

Relationship:______________________________________Phone: ____________________________________

Insurance Carrier: ____

Name of Policyholder if different than patient: ____

Birthdate of policyholder: ________________

Secondary Insurance Carrier (If Applicable): ____

Name of Policyholder if different than patient: ____

Birthdate of policyholder: ________________

How did you hear about us? ☐Physician Referral ☐Close to Home/Work ☐TV/Radio ☐Website ☐Social Media ☐Friends/Family ☐Other: ____

____

If under the age of 19 please list parents or legal guardian information:

Mother: ____

Home phone:_______________________Work: ______________________Cell: ___________________________

Father: ____

Home phone:_______________________Work: ______________________Cell: ___________________________

Authorization and Release

I certify that the information provided above is true and correct to the best of my knowledge and belief.

I authorize this clinic to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the physical therapist's office, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I understand I am responsible for all copays, deductibles, co-insurance and balances. I personally agree to pay for any and all services provided to me at the rates in effect during the time services are rendered. I understand and agree that my bill for services rendered is due and payable at the time of service and that I am ultimately responsible for any unpaid balances. A wide variety of means for communication exists and continues to broaden and develop. By signing this Authorization, I agree that this office, and any third party used for treatment, billing, collection and other services, may use any means of communication with me. Thus, I understand and agree that any phone numbers and email addresses provided by myself to this office and to any of our service providers, now and in the future, may be used as a means to contact me, and that this office and our service providers may leave messages for me manually and by using automated systems such as by artificial or prerecorded voice. Specifically, if I provide a cellular phone number, I consent and agree to accept collection calls and other communications to my cellular phone from this office and from any of our service providers. For any landline and cellular phone calls this office or any service providers place to me, I consent and agree that those calls may be automatically dialed and that this office and our service providers may use recorded messages. I also agree that this office and any service providers may contact me by sending text messages and emails to any phone number or email address I provide to this office or service providers, and I consent to receive such text messages and emails which may identify the name of this office or service provider sending the communication, and which may disclose the nature of the communication.

X ____

Signature of Patient/Guarantor

PERSONAL HEALTH HISTORY

Patient Name:____ Height:___________Weight: __________

Referring Doctor:______________________________________Primary Doctor: _________________________________

What are we seeing you for today? ____

How did injury/condition occur? ____

Injury occurred at: ____

Date of injury:______________________**OR** when did you first notice symptoms: ____________________

Have you recently or are you currently receiving home health care? : _____________

Have you had x-rays or an MRI taken? Yes ☐ No ☐

Results: __________________________________

Are you currently pregnant? Yes ☐ No ☐ Do you smoke? Yes ☐ No☐ If 'yes', how many packs per day: _____

Do you have any allergies? Yes ☐ No ☐

If 'yes', indicate what you are allergic to and reaction.

____

____

Use the pain scale described below to rate your pain for the questions below:

0 – Pain-free
1 – Very minor annoyance, occasional minor twinges
2 – Minor annoyance, occasional strong twinges
3 – Annoying enough to be distracting
4 – Can be ignored if you are really involved in your work/task, but still distracting
5 – Cannot be ignored for more than 30 minutes
6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities
7 – Makes it difficult to concentrate, interferes with sleep, but you can still function with effort
8 – Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain.
9 – Unable to speak, crying out or moaning uncontrollably, near delirium
10 – Unconscious, pain makes you pass out

0 ◄—1—2—3—4—5—6—7—8—9—► 10

______ What number on the pain scale (0-10) best describes your pain **right now**?

______ What number on the pain scale (0-10) best describes your **worst pain**?

______ What number on the pain scale (0-10) best describes your **least pain**?

Do you have, or have you had: (please check if yes)

☐ Arthritis	☐ Osteoarthritis	☐ Rheumatoid Arthritis	☐ Osteoporosis
☐ Kidney Disease	☐ Liver Disease	☐ Epilepsy	☐ Rheumatic Fever
☐ Cancer	☐ Diabetes	☐ Stomach Ulcers	☐ Cortisone Drug
☐ Heart Disease	☐ High Blood Pressure	☐ Angina / Chest Pain	☐ Anemia
☐ Stroke/TIA	☐ Depression	☐ Polio	☐ Tuberculosis
☐ Chronic Bronchitis	☐ Asthma	☐ COPD / Emphysema	☐ Other: ___________
☐ Peripheral Neuropathy		☐ Peripheral Artery Disease	☐ Diabetic Ulcer

Past Medical History: (Surgeries / Fractures) Year

____ ______________

____ ______________

____ ______________

MEDICATIONS

What medications are you taking now? (**Include prescription, over-the-counter drugs, supplements such as vitamins, and herbals**.)

Medication name	Dosage	Frequency	Route of Administration (ie: oral, injection)

Have you fallen in the last year? Yes___/ No____

If yes, how many times in the last year? ________________________

If you have fallen in the last year, were you injured? Yes / No If yes, please explain ________________________

____