Patient Demographics

First Name: _____

Last Name: _____MI: _____

Preferred Name: _____

Sex: MALE / FEMALE

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Home Address: _____

City: _____State:_____ Zip: _____

Date of Birth: _____/_____/_____ Social Security Number: _____ - _____ - _____

How did you hear about Physical Therapy Professionals? _____

Emergency Contact: _____ Relationship:_____ Phone #:_____

For billing purposes if you have an alternate address please list below. Please include the date range that you normally reside at this secondary address:

Address: _____

City: _____ State: _____ Zip: _____ Dates: _____

Please provide your email address below to avoid charges for mailing requested medical records and /or any outstanding financial statements. To ensure your privacy all email will be sent over a secure network and your address will not be shared publicly to any third party. If you have questions in regards to the above, please see the receptionist.

Email address: _____

I understand and agree that I am responsible for the balance of my account for any services rendered. I have read all the above information and the information provided is true and correct to the best of my knowledge. I will notify Physical Therapy Professionals of any changes with the above information. I hereby authorize any treatment(s) agreed upon with my physical therapist and my referring provider (if applicable) that are deemed medically necessary.

Patient Signature: _____ Date: _____/_____/_____

PHYSICAL THERAPY Professionals

Medical History

Patient Name: _____Referring practitioner: _____
Is this a Work related Injury? □ Yes □No Is this related to an Auto Accident? □ Yes □ No
Is there an attorney involved in this case? □ Yes □ No
Have you had surgery for this condition? □Yes □ No If yes, date: _____
Have you received previous treatment for this condition? □Yes □ No If yes please describe:
_____
Are you currently receiving or have you received in the last 30 days any home health, medical or chiropractic services rendered to you by any other agency? □Yes □ No If yes, please describe:
_____
Are you currently taking any medications **for this injury**? □YES □NO
□Anti Inflammatories □Muscle Relaxers □ Pain Medication □ Other: _____
At the present time, would you consider your overall health: □ EXCELLENT □ VERY GOOD □ FAIR □ POOR

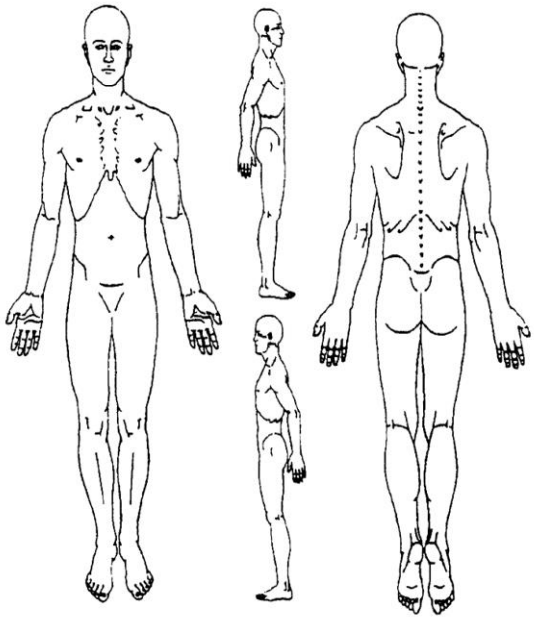
Females: Are you currently pregnant? □YES □ NO
Do you now have, or have you ever had any of the following?

Pacemaker and/or defibrillator	□ YES	□ NO
Diabetes	□ YES	□ NO
Coronary Artery Disease/Angina	□YES	□ NO
Shortness of Breath/Chest Pain	□YES	□ NO
Heart Attack/Heart Surgery	□ YES	□ NO
Latex Sensitivity/Allergy	□ YES	□ NO
Blood Clot	□ YES	□ NO
High Blood Pressure	□ YES	□ NO
Osteoporosis	□ YES	□ NO
Pin/Metal Implants	□ YES	□ NO
Asthma, Bronchitis or Emphysema	□ YES	□ NO
Headaches	□ YES	□ NO
Dizzy Spells/Fainting	□ YES	□ NO
Stroke/TIA	□ YES	□ NO
Thyroid Trouble/Goiter	□ YES	□ NO
Joint Replacement	□ YES	□ NO
Infectious Disease (explain below)	□ YES	□ NO
Arthritis	□ YES	□ NO
Sleeping Problems	□ YES	□ NO
Do you Smoke?	□ YES	□ NO
Numbness/Tingling	□ YES	□ NO
Weakness	□ YES	□ NO
Unexplained Weight Loss/Gain	□ YES	□ NO
Hernia	□ YES	□ NO
Epilepsy/Seizures	□ YES	□ NO
Recent changes in Bowel/Bladder	□ YES	□ NO

Allergies: _____
Cancer (Please Explain):_____
_____

On a scale of 0-10,
(0 being no pain and 10 being at its worst)
Please rate your pain at best ____ at worst ____

Please mark the areas on the diagram below where you feel the pain.



Please list any other health conditions:
_____
_____
_____
_____

Patient Signature:_____ Date: _____

Acknowledgement of Receipt
Notice of Privacy Practices

This facility will make every attempt to protect your privacy and personal information. We have provided a summary of your rights and protections under the federal health information privacy law. We would like to retain your signature to acknowledge the receipt of our notice of privacy practices.

I have received a copy of the notice of privacy practices at PT Professionals.
You will be offered a copy of the Notice of Privacy Practices on your first appointment

_____
Please Sign Name

_____
Date

Option to Give Access to Medical Records

I authorize_____(Examples: Spouse, Sibling, Parent, Caregiver) access to medical information pertaining to my treatment. Please note that PT Professionals will not share your information with any individual that is not directly involved with your case unless you specify otherwise.

Please note that if you are 18 years or older we will not release your information to any other individual that does not have a business associate agreement with PT Professionals.