



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: ____/____/____

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

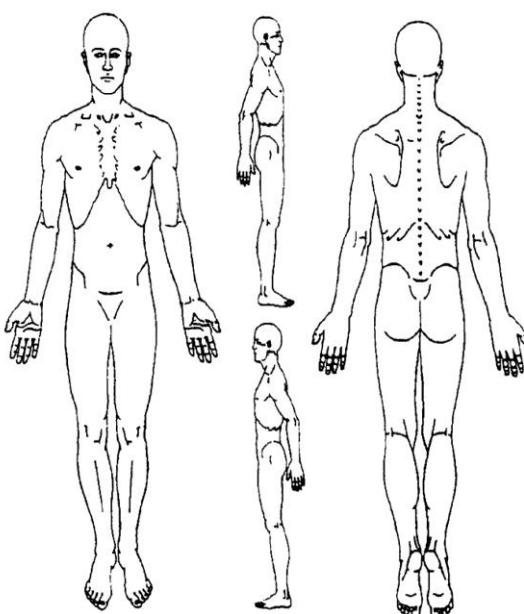
Females: Are you currently pregnant? YES NO

Do you now have, or have you ever had any of the following?

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