SPORTS & WELLNESS PHYSICAL THERAPY

ADULT PATIENT INFORMATION AND CONSENT FORM

Name:_____ Circle: M/F Date:_____
Last First MI

Address:_____
Street City State Zip

E-mail Address: _____

Phone: Home_____ Work:_____Cell:_____

Social Security Number:_____ Birthdate:_____Age:_____

Marital Status: Single ____ Married ____ Student: FT _____ PT _____ N/A _____

Emergency Contact Person:_____ _____ _____
Name Relation Phone

Other Contact:_____ _____ _____
Name Relation Phone

EMPLOYMENT

Employer:_____Job Title:_____

Address:_____Phone:_____ Ext.:_____

Status (mark appropriate): Full Time _____ Part Time _____ Unemployed _____ Retired _____

INSURANCE

TYPE: Private_____ Medicare____Auto_____ Worker's Comp____ Other_____
(mark appropriate) Specify

Primary Insurance Company:_____

Address:_____Phone:_____
Agent/Adjuster:_____
Policy #:_____ Group #:_____
Insured's Name(if different from patient):_____
Secondary Insurance Company:_____
`Address:_____Phone:_____
Policy #:_____Insured's Name:_____

PHYSICIAN

Name of Referring Physician:_____

Name of Family Doctor (if different):_____

Reason for Physical Therapy:_____ Is therapy due to a car accident? Yes No

Date of Injury (**please list**-approx.ok):_____Any Previous PT for Current Problems? Yes No___

What other treatments have been tried?_____

What was the outcome?_____

For Office Use Only

1° Dx Code_____

2° Dx Code_____

HISTORY

Do you now have/or have you had any of the following:

High Blood Pressure	YES	NO	Sensitive to Heat/Ice	YES	NO
Heart Disease	YES	NO	Allergies	YES	NO
Heart Attack	YES	NO	Hernia	YES	NO
Pacemaker	YES	NO	Seizures	YES	NO
Diabetes	YES	NO	Metal Implants	YES	NO
Headaches	YES	NO	Dizzy Spells	YES	NO
Kidney Problems	YES	NO	Balance Problems	YES	NO
Nervous Disorder	YES	NO	Vision Problems	YES	NO
Hearing Problems	YES	NO	Cancer	YES	NO
Speech Problems	YES	NO	Prior Hospitalizations	YES	NO

If YES on any of the above, please explain and give approximate dates_____

_____

Are you presently taking any medication? List_____

What is your occupation?_____ Describe the physical requirements of that job_____

_____

Do you have difficulty with any of the following activities (check all that apply; if checked, please be specific. i.e. time limits, distance, weights, etc.)

Sitting_____ Sleeping_____

Standing_____ Personal Care_____

Walking_____ Lifting_____

Driving_____ Other_____

Are you, or is there a chance you could be pregnant?_____

List any past surgeries and date of surgeries (approx.-ok):_____

_____

What benefits do you expect to gain from physical therapy? Be specific:

A._____

B._____

C._____

The above information is correct to the best of my knowledge.

I have read and fully understand Sports & Wellness Physical Therapy's Notice of Information Practices. I understand that Sports & Wellness Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Sports & Wellness Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Sports & Wellness Physical Therapy's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I hereby authorize my insurance company to pay directly to Sports & Wellness Physical Therapy medical benefits otherwise payable to me, and I will be responsible to Sports & Wellness Physical Therapy for all expenses incidental to treatment rendered not paid under this plan.

Signature:_____ Date:_____