



**ADULT PATIENT INFORMATION AND CONSENT FORM - PT**

Name: \_\_\_\_\_ Circle: M / F Date: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_  
Street City State Zip

E-mail Address: \_\_\_\_\_

*Your email address will be used for appointment reminders. Check here if you prefer reminders via automated phone call  or text   
It may also be used to send periodical newsletters and information about upcoming events. Check here to opt out*

Phone: Home \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

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? \_\_\_\_\_

**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 (*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 understand that a Cancellation Fee of \$100 may be charged if I cancel an appointment with less than 24 hours notice or fail to show up for an appointment.

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: \_\_\_\_\_