



ADULT PATIENT INFORMATION AND CONSENT FORM - PT

Name: _____ Birthdate: _____ Age: _____ Date: _____
Last First MI

Address: _____
Street City State Zip

E-mail Address: _____

Phone: Home _____ Cell: _____ Work: _____

Sex: M F Other Prefer Not to Answer Preferred Gender Pronoun: _____
(please circle)

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

Emergency Contact Person: _____
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 _____
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: _____ 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: 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? Please 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 **HIPAA Notice of Information Practices**. I understand 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 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 Sports & Wellness Physical Therapy will consider requests for restrictions 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 **HIPAA Notice of Information Practices**. I understand I retain the right to revoke this consent by notifying the practice in writing at any time.

I hereby consent to treatment and 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. **I understand a Cancellation Fee of \$50 may be charged if I cancel an appointment with less than 6 hours' notice or fail to show up for an appointment.**

Signature: _____ Date: _____