Prime Health Physical Therapy

WHEN HEALTH IS YOUR FIRST PRIORITY

PATIENT INFORMATION

Patient's Last Name	First	Middle	How would you like to be addressed?

Street Address	City	State	Zip Code

Home Phone	Work Phone	Cell Phone	Social Security Number (billing purposes)

E-mail Address	Date of Birth	Age	Sex Male Female

Occupation	Employer	Employer Address

Prescribing Physician's Name	Date of Last Physician Appt. / /	Date of Next Physician Appt. / /	How did you hear about our office?

INSURANCE / FINANCIAL INFORMATION

Type of Insurance	Subscriber's Name

Person Responsible for Bill	Responsible Party Address

Phone Number	Student Status Full-time / Part-time	Accident Status None / Auto / Work / Other:	Date of Injury

Workers' Compensation Claim # (If Applicable)	Claim's Adjuster	Adjuster's Phone Number

IN CASE OF EMERGENCY

Contact Name	Relationship to Patient	Home Phone	Work Phone

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

Can you perform your daily activities? Yes No (Describe)

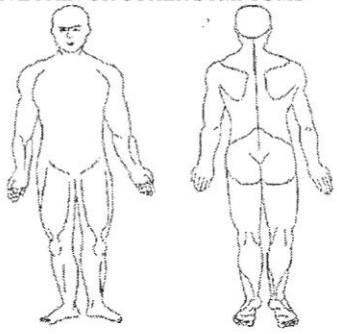
Have you ever had physical therapy for this condition? Yes No Year:

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



HAVE YOU RECENTLY NOTICED?

Yes No Weight Loss/Gain	Yes No Weakness	Yes No Dizziness
Yes No Nausea/Vomiting	Yes No Fever/Chills/Sweats	Yes No Bladder/Bowel Changes
Yes No Fatigue	Yes No Numbness or Tingling	Yes No Chest Pain

HAVE YOU EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS?

Yes No Heart Problems
Yes No High Blood Pressure
Yes No Circulation Problems
Yes No Rheumatoid Arthritis
Yes No Other Arthritic Conditions
Yes No Stroke
Yes No Lung Disease
Yes No Asthma
Yes No Pacemaker
Yes No Diabetes

Yes No Hearing Loss/Disorder
Yes No Eye Disease
Yes No Muscular Disease/Disorder
Yes No Multiple Sclerosis
Yes No Tuberculosis
Yes No Epilepsy/Seizures
Yes No Hepatitis
Yes No Kidney Disease
Yes No Thyroid Problems
Yes No Implanted Devices

Yes No Cancer
Yes No Osteoporosis
Yes No Depression
Yes No Past Pregnancy
Yes No Current Pregnancy
Yes No Chemical Dependency
Yes No Ulcers
Yes No Other: _____

LIST SURGERIES, MEDICAL CONDITIONS OR INJURIES FOR WHICH YOU HAVE BEEN TREATED

_____ Date: _____

_____ Date: _____

Date:

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (PILLS, INJECTIONS, INHALERS, ETC.)

_____

_____

_____

The above information is true to the best of my knowledge. I hereby authorize Prime Health Physical Therapy Center, to release any and all information concerning my care to my insurance company. I further authorize payment directly to Denton Sports & Physical Therapy Center, and I understand that I am financially responsible for all charges not covered by my insurance payments.

X _____

PATIENT/GUARDIAN SIGNATURE **DATE**

HIPPA Privacy Practices Acknowledgement

See attached notice on clipboard

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name_____ Birth Date_____

Signature_____ Date_____

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