Patient Information

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Birth date: _____ Age: _____ Social Security #: _____

Gender: **M** **F** Marital Status: Married Single Divorced Widow Other

Employer: _____ Work Phone: _____

Referring Provider: _____ Date of last visit: _____

How did you hear about us? _____

Insurance Information

Primary Insurance: _____ ID# _____ Group # _____

Secondary Insurance: _____ ID# _____ Group # _____

If this condition is related to a work injury ot auto accident, please provide the following information:

Insurance Carrier: _____ Date of Injury: _____ Claim # _____

Adjustor's Name: _____ Phone #: _____ Fax: _____

Claim Address: _____

Patient Authorized Signature: *I hereby authorize release of medical or other information necessary to process this claim. I also allow assignment of insurance payments to Therapy Works Physical Therapy for services described on insurance form.*

Signed: _____ Date: _____

I have read and understood the Notice of Privacy Practices (HIPAA notice) and consent to allow Therapy Works Physical Therapy to disclose my protected health information for treatment, payment and health care operations. I furthermore consent to treatment by the therapists working for and with Therapy Works Physical Therapy. I understand that with all medical interventions there are risks involved and that no guarantee for an outcome may be made.

Signed: _____ Date: _____

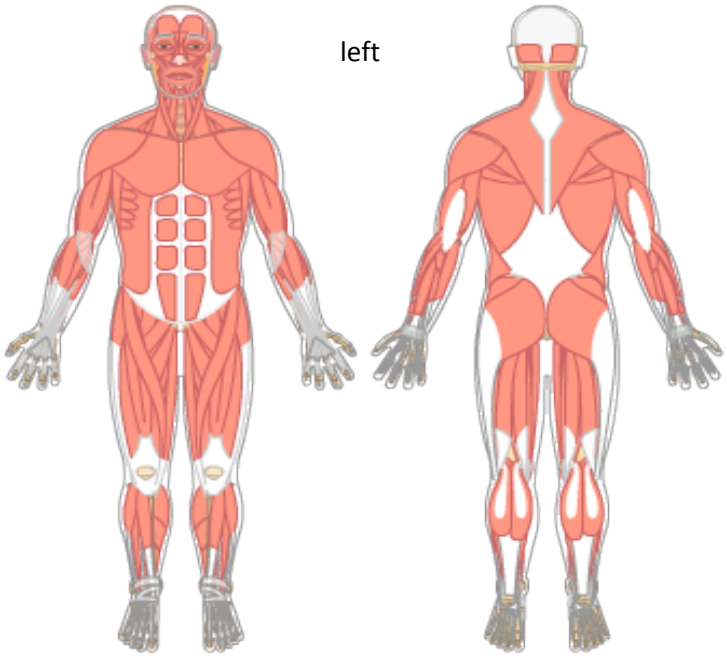
Patient Assessment

Name: _____

Physician: _____ Diagnosis: _____ DOB: _____

Please shade in all the problem areas:

right left right



1. What is your primary complaint?

_____

_____

2. Describe the history of your primary complaint, including the date of onset:

_____

_____

3. Please rate your pain on a scale of 1 - 10

1 ⟷ 10

No pain Intense pain

4. How often is your sleep disturbed by these sypmtoms?

_____

5. Describe what you cannot do because of these symptoms

_____

_____

6. What previous treatments or diagnostic tests have you had for these symptoms?

_____

_____

7. What is your occupation? Are there any repeated activities that are difficult for you?

_____

_____

8. Please indicate your stress level

0 ⟷ 10

No stress — High Stress

9. What are your recreational activities and what is your exercise frequency?

_____

10. What do you hope to achieve with physical therapy?

_____

Past Medical History

11. Have you ever had or been diagnosed with any of the following conditions? (Check all that apply)

☐ Cancer (type) _____	☐ Heart Problems	☐ Arthritis
☐ Depression	☐ High Blood Pressure	☐ Head Injury
☐ Stroke	☐ Lung Problems	☐ Stomach Problems
☐ Kidney Problems	☐ Blood disorders	☐ Parkinsons Disease
☐ Thyroid problems	☐ Epilepsy/seizures	☐ Osteoporosis
☐ Diabetes (Type) _____	☐ Allergies	☐ Broken Bone
☐ Multiple Sclerosis	☐ Rheumatoid Arthritis	☐ Other _____
☐ Infectious diseases (Hepatitis, tuberculosis etc)	☐ Circulation/Vascular problems	

What medications are you currently taking?

_____

Please list any past injuries, accidents or surgeries below (include date):

_____

_____

Financial Policy Information

Please carefully review our financial policy.

The Financial Policy is available for download here:

http://therapyworkspt.com/pdf/Financial-Policy.pdf