Patient Information Form

Patient Information

Last Name _____ First Name _____ MI ____ SSN _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Home Phone ( ) - _____ Work Phone ( ) - _____ Cell Phone ( ) - _____

Date of Birth _____ Gender _____ Marital Status _____ Email _____

Emergency Contact

Last Name _____ Relationship _____

First Name _____ Phone ( ) - _____

Employer

Name _____ Phone _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Problem

Problem Description _____ Date of Injury _____ Last Physician Visit / /

Referred By _____ Primary Care Physician _____

Latest Referral Information _____ Motor Vehicle Accident ____

Latest Plan of Care _____ That occurred in: ____

Primary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Secondary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Tertiary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

I authorize payment and release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to allow said facility to evaluate and treat my condition and symptoms.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. This office utilizes a variety of measures to protect your identity and others..

Signature:_____ Date:_____

Registered Date:

Last Name: **First Name:** **MI:**

HOW DID YOU HEAR ABOUT US?

___ Facebook __ Website ___ Internet Search ___ Yellow pages

__ Newspaper __ Billboard __ Friend/relative/physician ___ I was a prior patient ___ Facility/Agency

If applicable, Who can we thank for referring you to our office?

EMPLOYMENT INFO

__Not employed __Retired __Student ___ Employed Full-Time ___Employed Part Time

Employer Name:

Address:

City: State: Zip:

Job Title:

WORK RELATED INJURIES

Is your injury work related? Y / N *(Above employer Info REQUIRED if work related!)*

Date of Injury? _____

ACCIDENT RELATED INJURIES

Is your injury the result of an accident? Yes / No Type: Auto / Liability *(circle one)*

If Liability, please describe: _____

If you are receiving care because of an auto accident, what state did the accident occur in? _____

Date of Injury? _____ **Do you have an attorney helping you?** Yes / No / Considering

Attorney name: _____ Phone:_____

NURSING SERVICES

Have you recently received any Nursing Services?

Home Health? Yes / No Agency _____

Hospice? Yes / No Agency _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize the person(s) listed below to access my health information and/or make decisions, provide and/or request information on my behalf. I grant permission to handle any paperwork, payment info, scheduling appointments, and/or medical records.

_____ _____

_____ _____

_____ _____

PATIENT OR GUARDIAN AGREEMENT

Parent or Guardian Signature required for anyone 17 years or younger

X *I agree to freely participate in evaluation, treatment, and re-evaluation as deemed necessary by the facility and/or practitioner. I authorize that the information I disclose to my therapist throughout the course of treatment is accurate to the best of my knowledge. I agree to notify the office staff within 24hrs. should any adverse reactions to treatment I received at this facility occur.*

X *I authorize release of information from other medical providers to this facility via fax.*

X *I authorize information obtained by this facility may be disclosed to other medical providers for collaboration or to insurance providers/ guarantors as requested in order for payment to be considered.*

Signature of Patient or Guardian: _____Date ____/____/____

Are you CURRENTLY receiving any other Health Services:

☐Chemotherapy
☐Chiropractic
☐ Nursing Services through home health _____
☐ Nutritional/Dietetic Services
☐ Occupational Therapy
☐ Physician
☐ Psychology
☐ Radiation Therapy
☐ Speech Therapy
☐ Social Services
☐ Respiratory Therapy
☐ Hospice

 # Symptoms:

☐Hypersensitivity
☐Numbness
☐Pain Rating ____ /10
0=no pain, 10= unbearable
☐Paresthesia
☐Poor Balance
☐Poor Endurance
☐Poor Stability
☐Vertigo
☐Weakness
☐Swelling

Other:

Activities of **D**aily **Li**ving

***PRIOR** to this Episode/ Injury:

I was able to perform all activities independently.

I needed some help with _____

Dominant Hand: ☐Left ☐Right

***Caregivers:**

☐ I care for myself and others.
☐ I live alone and do everything without help.
☐ I get some help from others for _____

AGE:_____HEIGHT:_____ WEIGHT:_____ Any significant change in past 12 months? ☐Yes ☐No

Do you use tobacco products? ☐Yes, Frequency?_____ ☐No

Primary Limitation: Currently, I am unable to _____

Prior Surgeries, year performed: _____☐ No Prior Surgeries

Prior injuries:_____☐ No Prior Injuries

Have you ever been diagnosed or treated for.. __ Arthritis __ RA __ Balance disorders __ Cancer __ COPD __ cardiac conditions __ Diabetes __ epilepsy __ headaches/migraines __ hypertension __ neurological

Other: _____

Is Pain aggravated by any certain activities or positions? _____

Is your pain worse during a particular Time of the Day? __ Morning ___Mid-Day ___ Afternoon ____ Night

Do you experience any Sleep Disturbance: ☐No ☐Yes

Your expectation for therapy? _____

Your ability to attend therapy may be difficult due to _____

Current Medications: Include all Prescriptions, over-the-counter, herbals, vitamins, minerals, dietary, or nutritional supplements

Name	Taken for:	Dosage	Frequency	Route Taken?
				_Oral _IV __injection __topical

LETTER OF PROTECTION

REQUIRED FOR ALL LIABILITY INJURIES

Patient Name: Patient DOB:

I, _____(Patient Name), in consideration of the provider providing physical/ occupational/ speech therapy treatment hereby authorize and direct my attorney or liability insurance to pay directly to the providing clinic out of the proceeds resulting from any settlements, judgments, or verdict in or of my case or out of payment from any insurance company obligated to reimburse me for charges made for services rendered. A lien against the proceeds of any settlement, judgment, or verdict in or of my case for physical / occupational / speech therapy treatment provided to me by the providing clinic arising out of injuries suffered on _____ (Injury Date).

I understand that I am directly responsible to _____(Clinic Name) for all professional bills submitted by the clinic for services rendered to me and that this agreement is made solely for the providing clinic's additional protection and in consideration of it awaiting payment. I also understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover moneys.

Furthermore, should I choose to retain different legal representation, I will notify the clinic staff within 10 (ten) days of such a change.

Signed: _____ Date: _____

Patient's signature or legal guardian

The undersigned attorney hereby agrees to observe all of the terms of the above, and agrees to withhold from any settlement, judgment, verdict, or insurance payment such sums as are necessary to pay for the physical / occupational / speech therapy treatment provided by _____ (Clinic Name) to the above named patient.

Signed: _____ Date: _____

Attorney's Signature