PATIENT INFORMATION:			
Last Name:	First Name:	MI:	SSN:
DOB:	Gender: Male / Female	Email:	
Address:	City:	State:	Zip:
Home Ph:	Work Ph:		
Cell Ph:	Cell Ph. Carrier:		
__ I agree to have text message reminders sent to me at the cell phone # above			
__ I agree to have email appt. reminders sent to me at the above email address.			
__ I agree to have clinic communications sent to me at the above email address (announcements, exercise programs, etc.)			
If you do not want phone messages to be left for you, please note that here:			
EMERGENCY CONTACT:			
Relationship:	Phone:	Name:	
I authorize the person(s) listed below to access my health information and/or request information on my behalf: ______________________________ ______________________________			
I grant permission to the below person(s) to make decisions, handle any paperwork, payment information, scheduling appointments, and/or access to my medical records on my behalf. ______________________________ ______________________________			
HOW DID YOU HEAR ABOUT US?			
__ Facebook __ Website __ Internet Search __ Yellow pages __ Newspaper __ Billboard __ Facility/agency __ Friend/relative __ Physician __ Payer __ I was a prior patient If applicable, who can we thank for referring you to our office? ______________________________			
EMPLOYER:	__ Retired ___ Not employed __ Student		
Company Name:	__ Full time __ Part time		
Phone:	City:	State:	
What is your occupation?			
PRIMARY INSURANCE:			
Insurance:		Subscriber Name:	
Member ID:	Group #	Subscriber DOB:	Relationship:
SECONDARY INSURANCE:			
Insurance:		Subscriber Name:	
Member ID:	Group #	Subscriber DOB:	Relationship:
TERTIARY INSURANCE:			
Insurance:		Subscriber Name:	
Member ID:	Group #	Subscriber DOB:	Relationship:
ACKNOWLEDGMENTS/CONSENTS: Initial each line			
______ 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 reviewed the Notice of Privacy Practices and have been offered a copy. This office utilizes a variety of measure to protect your identity and others.			
______ I agree to freely participate in evaluation, treatment, and re-evaluation as deemed necessary by the facility and/ or practitioner. I authorize 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 said facility within 24hrs. should I experience any adverse reactions to treatment I received at this facility.			
______ I authorize release of information from other medical providers to CLINIC NAME by fax to CLINIC FAX.			
______ I authorize information obtained by this facility may be disclosed to other medical providers for collaboration or to insurance providers and/or guarantors as requested in order for payment to be considered.			
Patient/Guardian Signature:		**Date:**	

OTHER SERVICES:

Have you received any home nursing services, home health, or hospice services in the past 60 days? Yes / No
If yes, what agency?

Who have you seen for this condition before today? ___ No one
__ Physician __ Massage Therapist __ Chiropractor __ Acupuncturist __ Athletic Trainer
__ Physical Therapist __ Occupational Therapist __ Speech Therapist Other: ______________________________
What treatments were received and when? ____

Have you had x-rays, MRI, CT Scan for this condition? When and where?

REASON FOR TREATMENT:

Referred by: Primary Care Physician:

Describe your current Problem and how it began:

Onset/Injury/Surgery Date:	Is your injury work related? Yes / No

Is your injury the result of a motor vehicle accident? Yes / No If yes, what state did the accident occur in?

Do you have an attorney helping you with the resolution of this injury? Yes / No
If yes, please include the attorney name and Phone #:

Height: Weight: Dominant Hand: Left / Right

Choose the most appropriate response to the following:

Symptoms are? __ Constant 76-100% of the day __ Come/Go 26-75% of the day __Only with activity
Symptoms are? __ Getting worse __ Not changing __ Getting better

Please select ALL responses that apply:

Do you have any difficulty with: __ Sleeping __ Seeing __ Hearing __ Talking __ Memory __ Swallowing
__ I care for myself and others __ I live alone and do everything without help
I get some help from others for:

Which activity causes you the most pain/ most difficulty performing? ________________________________

Function: Rate your ability to perform the above activity

Difficult No difficulty
0 1 2 3 4 5 6 7 8 9 10

Pain at Worst: Highest pain in the last week

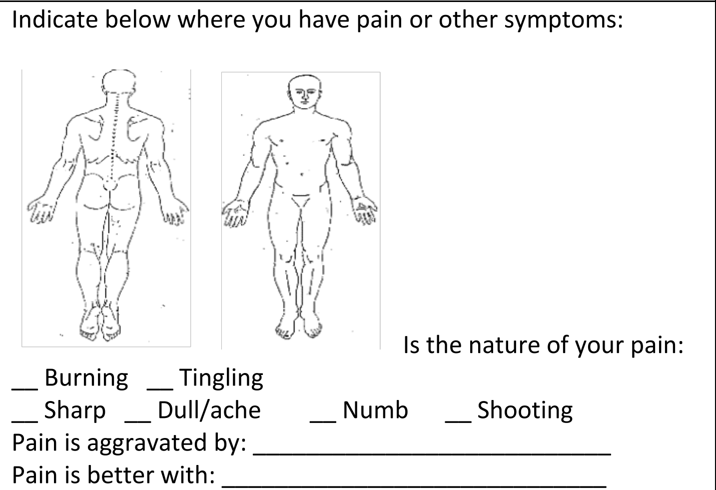
No pain Worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Pain at Best: Lowest pain in the last week

No pain Worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Is the pain worse at a particular time of day? _________

Indicate below where you have pain or other symptoms:



Is the nature of your pain:
__ Burning __ Tingling
__ Sharp __ Dull/ache __ Numb __ Shooting
Pain is aggravated by: ____________________________
Pain is better with: ______________________________

PAST MEDICAL HISTORY:

Have you been diagnosed or treated for:
__ Arthritis/ RA __ Cancer __ Balance issues
__ COPD __ Hepatitis __ cardiac conditions
__ Diabetes __ Epilepsy __ headaches/migraines
__ TB __ Hypertension __ Neurological conditions
Do you have a pacemaker? Yes / No
Other:

Prior Injuries:

Prior surgeries & year performed:

MEDICATIONS:

Name:	Taken for:

LETTER OF PROTECTION

REQUIRED FOR ALL LIABILITY INJURIES

Patient Name: ____________________ Patient DOB:_____________

I, ____________________________________, in consideration of The Therapy Center of Jefferson Davis Parish, Inc and/or Lemoine Therapy Services of CENLA, Inc. providing physical/ occupational/ speech therapy treatment hereby authorize and direct my attorney or liability insurance to pay directly 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 by The Therapy Center of Jefferson Davis Parish, Inc and/or Lemoine Therapy Services of CENLA, Inc. 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 Therapy Center of Jefferson Davis Parish, Inc and/or Lemoine Therapy Services of CENLA, Inc. arising out of injuries suffered on ______________ (Injury Date).

I understand that I am directly responsible to The Therapy Center of Jefferson Davis Parish, Inc. and/or Lemoine Therapy Services of CENLA, Inc. for all professional bills submitted by The Therapy Center of Jefferson Davis Parish, Inc and/or Lemoine Therapy Services of CENLA, Inc. for services rendered to me and that this agreement is made solely for The Therapy Center of Jefferson Davis Parish, Inc and/or Lemoine Therapy Services of CENLA, Inc. additional protection and in consideration of its 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 Therapy Center of Jefferson Davis Parish, Inc and/or Lemoine Therapy Services of CENLA, Inc. 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 The Therapy Center of Jefferson Davis Parish, Inc and/or Lemoine Therapy Services of CENLA, Inc. to the above named patient.

Signed: ____ Date: ________________________

Attorney's Signature