

PATIENT INFORMATION FORM

All Patients or Patients' Legal Representative, please complete all Sections

(1) Patient: (Full Legal Name or as on Insurance Card)

Preferred Language: _____

Name: _____
Last First Initial Sr. Jr.

Address: _____
Street Apt# City State Zip Code

Phone: (____) _____ - _____ (____) _____ - _____ (____) _____ - _____ Sex: M F
Home Mobile Work

DOB: ____ / ____ / ____ Soc Sec #: ____ - ____ - ____ Marital Status: M / D / S / W / Other

Email: _____ Employer: _____

(2) Emergency Contact

Name: _____
Last First Initial Sr. Jr.

Relationship: _____ Phone: (____) _____ - _____
Home / Mobile / Work (Please Circle)

(3) Doctor Information: Please provide Doctor who referred you to therapy below:

Name: _____ Phone: (____) _____ - _____ Fax: (____) _____ - _____
Last, First (MD, DO, DPM, Other)

Please provide your Family/Primary Care Doctor below (if different than above):

Name: _____ Phone: (____) _____ - _____ Fax: (____) _____ - _____
Last, First (MD, DO, DPM, Other)

(4) Condition to be treated: _____

Is it Related to an Auto Accident? No Yes Date of Accident ____/____/____ State: _____

Is it a Non Work-Related Accident? No Yes Date of Accident ____/____/____ State: _____

Is it a Work-Related Accident? No Yes Date of Accident ____/____/____

If Not Accident Related: Date Condition/Symptoms Began: ____/____/____

Did this Accident/Condition Result in Surgery? No Yes If Yes; Date of Surgery ____/____/____

Do you use: Walker/Rolling Walker/Rollator Cane Manual Wheelchair Motorized Wheelchair

If yes to any of the above, what condition necessitates the use of assistance? _____

Have you had PT / OT / Chiropractic Services for this Condition? No Yes (if yes, see below)

Are You Currently Receiving Any Home Health Services? No Yes (if yes, see below)

(ie: Any healthcare worker, aide assisting or doing something to or for you)

If Yes to above: Facility name: _____ Service Type: _____

Approximate Dates Attended: _____ Approximate # of Visits: _____

COMMERCIAL INSURANCE PAYOR FORM

(5) If Filing Insurance: Check A or B

A. ___ Patient is the insured (Skip to Section 7)

B. ___ Insured is ___ Spouse ___ Parent (Complete all of Section 6)

(6) Insured Person: (Full Legal Name or as on Insurance Card)

Name: _____
Last First Initial Sr. Jr.

Address: _____
Street Apt# City State Zip Code

Phone: (____) _____ - _____ (____) _____ - _____ (____) _____ - _____ Sex: M F
Home Mobile Work

DOB: ____ / ____ / ____ Soc Sec #: ____ - ____ - ____ Employed ___ Unemployed ___ Retired ___

(7) Employer Information (Please complete if the insured person's employer is the source of benefits)

Employer Name: _____ Employer Phone (____) _____ - _____

Address: _____
Street City State Zip Code

(8) Payor Information:

Primary Insurance Company: Insured is: ___ Patient ___ Spouse ___ Parent

Ins. Co. Name: _____ Ins. Ph # _____

Patient ID/Policy # _____ Group # _____

Claims Mailing Address: _____
Street City State Zip Code

Secondary Insurance Company: Insured is: ___ Patient ___ Spouse ___ Parent

Ins. Co. Name: _____ Ins. Ph # _____

Patient ID/Policy # _____ Group # _____

Claims Mailing Address: _____
Street City State Zip Code

(9) Medicare Patients Only:

Retirement Date: ____ / ____ / ____

Do you have Traditional Medicare? No Yes

Do you have Rail Road Medicare? No Yes

Are you covered under: Black Lung Disease End Stage Renal Disease Veterans Affairs

Large Group Insurance, if yes Name/Group: _____

PATIENT INFORMATION FORM

(10) Medications: Include All prescriptions, over the counter drugs, herbal and nutritional supplements
Separate List Provided? Yes No If No, please complete this section

Medication/Drug Name	Dosage	Times Per Day

(11) Demographic Information:

Where do you live? Private Home or Apt Assisted Living or Group Home Long-Term Care Facility
 Other: _____

Who do you live with? Alone Spouse/Significant Other Child/Children Group Setting
(check all that apply) Personal Care Attendant Other: _____

Employment status: Full-time, outside home Full-time, in home Retired Unemployed
(check all that apply) Part-time, outside home Part-time, in home Modified duty due to current injury
 Not working due to current injury Other: _____

Does your occupation involve: Sitting at a computer for prolonged times Manual Labor Homemaker
 Homemaker with small children Other: _____

What are your hobbies? _____

Are you currently able to participate at the level and frequency you would like? No Yes

(12) Past Medical History:

Height: ____ ft. ____ in. Weight: _____ lbs.
Do you have a Pacemaker? No Yes
Are you a Diabetic? No Yes If yes, for how long? _____
Are you a Smoker? No Yes If yes, for how long? _____
Are you pregnant? No Yes If yes, how many months? _____

In general, how would you rate your overall health right now? Excellent Good Fair Poor
Have ever received PT / OT? No Yes If yes, for what condition and what did you like/dislike about treatment?

List All Health Problems, Hospitalizations, Surgeries and Allergies or provide a list to your therapist

PATIENT INFORMATION FORM

THE FOLLOWING QUESTIONS ARE FOR PATIENTS WHO ARE HERE AS A RESULT OF AN INJURY, CONDITION OR PAIN (NON-SURGICAL).

1. Describe your current symptoms: _____

2. Did your symptoms begin as a result of a specific injury or gradual onset? Injury Gradual Onset
Explain: _____

3. How often are Symptoms Experienced? Constantly (76-100% of day)
 Frequently (51-75% of day)
 Occasionally (26-50% of day)
 Intermittently (0-25% of day)

4. What is your average pain intensity? Last 24 hours / Past Week / Last 4 Weeks (**circle one**)
None Unbearable
0 1 2 3 4 5 6 7 8 9 10

5. How much have your symptoms interfered with your work, hobbies or daily activities?
 Not at All A Little Bit Moderately Quite a Bit Extremely

6. How are your symptoms changing?
 Improving Not Changing Worse

7. Who have you seen for your injury or symptoms?
 No one Chiropractor Medical Doctor Physical / Occupational Therapist
 Other: _____

8. What treatment have you received for your injury or symptoms and when (approximately)?

9. What tests have you had related to your injury or symptoms? XRays MRI CT Scan
 Other: _____