PIERCE
PHYSICAL THERAPY

PATIENT CONTACT INFORMATION : **TODAYS DATE:** _________

Title: □ Mr. □ Mrs. □ Ms. □ Dr. **Date of Birth**: _________ **Gender:** □ Male □ Female

Last Name_____ **M.I.** _____ **First Name**_____

Address_____

City_____ **State**_____ **Zip Code**_____

Home Phone: (_____)_____ **Work Phone**: (_____)_____

Cell Phone: (_____)_____ Text messages? □ YES □ NO

E-mail address: _____

How would you like to receive appointment reminders? □ Text □ E-mail □ Voice mail

Marital Status: □ SINGLE □ MARRIED □ DIVORCED □ WIDOWED □ OTHER

Student: □ YES □ NO

Medicare Patients **ONLY**: Social Security Number: _____-_____-_____

EMERGENCY CONTACT: _____ Phone: _____

Relationship to patient: _____

EMPLOYMENT STATUS: □ EMPLOYED □ UNEMPLOYED □ RETIRED □ HOMEMAKER

Employer Name: _____ Employer City: _____

Supervisor: _____ Employer Phone: _____

Is this visit the result of a work related accident?: □ YES □ NO Date of Accident: _________

Worker Compensation Information:_____

RESPONSIBLE PARTY: (Complete only if different from patient**)**

□ SELF □ SPOUSE □ CHILD □ PARENT □ OTHER _____

Last Name_____ M.I. _____ First Name_____

Address_____ Date of Birth: _________

City_____ State_____ Zip Code_____

Phone number (_____)_____ Relationship to patient_____

INSURANCE INFORMATION: (Please present current insurance card to receptionist)

Primary Insurance Name _____ Who is insured? □ Self □ Other

If "Other", Name_____ SS#_____DOB_____

Relationship to patient_____

Secondary Insurance Name _____ Who is insured? □ Self □ Other

If "Other", Name_____ SS#_____DOB_____

Relationship to patient_____

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Case #_____ (Office Use Only)

TODAYS DATE: _______________

What is the reason for your visit today?_____

What is the location of your pain?_____

When did this problem begin?_____

Is this a work related injury? □Yes □No Date of injury: _____

Is this worker compensation case? □Yes □No

Is this the result of an auto accident? □Yes □No Date of injury: _____

My symptoms are: □ **Constant** (all day pain regardless of position or activity)
□ **Intermittent** (change with activity or position)

Things that worsen my symptoms: _____

Things the reduce my symptoms: _____

Doctor who referred you: _____

Family Doctor: _____

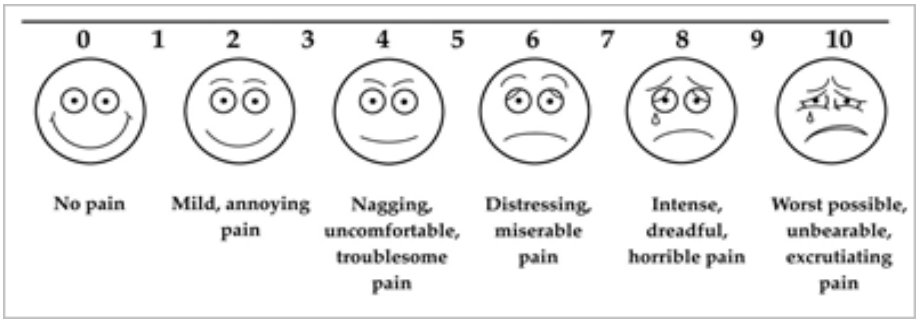
Please list any surgeries or injuries related to your visit today:

_____

_____

_____

Please rate your pain by **CIRCLING** the number (if applicable):



Health History Questionnaire (Confidential)

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First Name:_____
Last Name:_____
Date of Birth: _____/_____/_____

Do you have, or have you ever had any of the following?

Yes	No		Yes	No	
□	□	AIDS/HIV Positive	□	□	Nervous Disorder
□	□	Alzheimers			If yes, explain:_____
□	□	Amputation	□	□	Numbness of Extremities
		If yes, explain: _____			If yes, explain: _____
□	□	Ankylosis of Joints	□	□	Mental Disorder
□	□	Arteriosclerosis			If yes, explain: _____
□	□	Artificial Joint	□	□	Multiple Sclerosis
		If yes, explain: _____	□	□	Muscle Injury
□	□	Osteoarthritis			If yes, explain: _____
□	□	Rheumatoid Arthritis	□	□	Muscular Dystrophy
□	□	Asthma	□	□	Parkinson's Disease
□	□	Back/Neck Pain	□	□	Reflex Sympathetic Dystrophy
		If yes, explain: _____	□	□	Rotator Cuff Injury
□	□	Blood Clots			If yes, explain: _____
□	□	Blood Disease	□	□	Ruptured Disc
□	□	Cancer			If yes, explain: _____
		If yes, explain: _____	□	□	Shingles
□	□	Carpal Tunnel Syndrome	□	□	Spinal Fusion
□	□	Chronic Headaches			If yes, explain: _____
□	□	Diabetes	□	□	Stroke
□	□	Dizziness			If yes, explain: _____
□	□	Double Vision	□	□	Tumors or Growths
□	□	Emphysema			
□	□	Epilepsy or Seizures			
□	□	Head Injury			
□	□	Heart Condition			
		If yes, explain:_____			
□	□	Hepatitis A			
□	□	Hepatitis B or C			
□	□	High Blood Pressure			
□	□	Ligament or Tendon Injury			
		If yes, explain: _____			
□	□	Loss of Use of Limbs			
		If yes, explain: _____			
□	□	Latex Allergy			
□	□	Lung Disease			

Are you using, or have you ever used any of the following:

□	□	Alcohol
		If yes, explain: _____
□	□	Tobacco in any form
		If yes, explain: _____
□	□	Recreational Drugs
		If yes, explain: _____
□	□	Over-the-counter medicines
		If yes, explain: _____
□	□	Natural remedies
		If yes, explain: _____

Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain: -

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform Pierce Physical Therapy of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: _____**DATE**:_____

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CONSENT TO TREATMENT

I understand that I have been referred for physical therapy treatment to Pierce Physical Therapy PC. Pierce Physical Therapy PC will provide an individualized treatment plan. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to this treatment plan that has been prescribed by my physician and/or recommended by my physical therapist. By signing this agreement, I consent to have Pierce Physical Therapy PC provide treatment and care as prescribed by my physician and/or recommended by my therapist.

Patient Signature_____**Date**_____

CREDIT AND BILLING POLICY

Unless previous arrangements have been made, co-pays are appreciated at the time of service. Following your initial visit, we will provide you with all of the verification information that your insurance company has provided. We also encourage you to contact your insurance company to verify benefits. The cost of services is ultimately the responsibility of the patient.

CANCELLATION POLICY

Please provide at least 24 hour notice if you are unable to keep your scheduled appointment

ASSIGNMENT OF BENEFITS

I authorize any benefits payable under my insurance plan for services proved to be paid directly to Pierce Physical Therapy PC. I also authorize release of any information required in the course of my evaluation and treatment to the appropriate agencies. I understand that I am responsible for any amount not covered by my insurance. **Medicare patients only:** I request that payment of authorized Medicare benefits be made to Pierce Physical Therapy PC for services provided. I also authorize release of medical information.

Patient Signature_____**Date**_____

Pierce Physical Therapy, PC

Acknowledgement of Receipt of Notice of Privacy Practices

Pierce Physical Therapy, PC reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the Notice of Privacy Practices for Pierce Physical Therapy, PC

_____

Name of Patient (Print or Type)

_____ **Date**: _____

Signature of Patient

_____ **Date:** _____

Signature of Patient Representative (Required if patient is a minor or adult who is unable to sign this form)

_____

Relationship of Patient Representative to Patient