|  |
| --- |
| **Patient Information** |
| Patient Name (Last, First, MI) | Sex | Marital Status | Date of Birth | Social Security No. |
| Street Address | City, State, Zip | Home Phone |
| Employer | Employer Address | Work Phone |
| Email Address |  Please check here if you would like to receive reminders and other communications by text Cell Phone: |
| **Emergency Contact** |
|  |
| Name | Relation to Patient | Phone Number |
|  |
| PLEASE PROVIDE STAFF WITH A PHOTO ID AND YOUR INSURANCE CARD SO THAT WE MAY PUT A COPY IN YOUR CHART. |

 **Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_\_\_**

**PREMIER HAS RECEIVED A REFERRAL FROM YOUR MD FOR TREATMENT OF:**

|  |
| --- |
|  |

Are you currently taking any of the following medications:

Pain [ ] Yes [ ] No Anti Inflammatories [ ] Yes [ ] No Muscle Relaxants [ ] Yes [ ] No

List Any Other Medication you are taking**:**

**Yes/No Yes/No**

|  |  |  |
| --- | --- | --- |
| [ ]  [ ] Do you have a PACEMAKER | [ ]  [ ] History of Cancer/tumors  | [ ]  [ ] High blood pressure  |
| [ ]  [ ] Seizures/nerve disorder | [ ]  [ ] Stroke (CVA) | [ ]  [ ] Joint replacement ? |
| [ ]  [ ]  Are you pregnant?  | [ ]  [ ]  Heart disease | [ ]  [ ] Diabetes |
| [ ]  [ ] Dizziness-blackouts  | [ ]  [ ] Gout | [ ]  [ ] Auto-Immunity disorders |
| [ ]  [ ] Increased thirst/ hunger | [ ]  [ ]  Do you have 24 hr pain? | [ ]  [ ]  Do you awaken from pain? |
| [ ]  [ ] Night/Sleep Disturbances | [ ]  [ ] Irregular headaches  | [ ]  None Reported |
|  |  |  |
| [ ]  [ ]  \*Do you smoke?  **How Many Daily? Weekly?** |  |
| [ ]  [ ]  Do you drink? **How Many Daily? Weekly?** |  |

**\*PLEASE BE ADVISED THAT SMOKING MAY DELAY YOUR HEALING PROCESS.**

How did your injury occur?

Have you been hospitalized for the current problem? [ ] Yes [ ] No

Have you had surgery for the current problem? [ ] Yes [ ] No

Have you had any other previous surgeries:[ ] Yes [ ] No

What is your occupation/job title**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Are you currently working**?** [ ] Yes [ ] No [ ] Full Duty [ ] Light Duty [ ] Full Time [ ]  Part Time

Have you attended physical therapy for the current injury: [ ] Yes [ ] No How Long? \_\_\_\_\_\_\_\_\_\_\_\_

Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check any of the following that you have consulted with for your current injury:

[ ]  Pain Specialist [ ]  Orthopedic MD [ ]  Chiropractor [ ]  Lawyer

Check any that increase your pain:

|  |  |  |
| --- | --- | --- |
| [ ] Sitting | [ ] Standing  | [ ] Walking |
| [ ] Reaching  | [ ] Kneeling  | [ ] Squatting  |
| [ ] Bending  | [ ] Dressing | [ ] Daily Activities  |
| [ ] Driving  | [ ] Sleeping  | [ ] Pushing  |
| [ ] Pulling  | [ ] Exercise  | [ ] Carrying  |
| [ ] Lifting | [ ] Stooping | [ ] Ascending Stairs  |
| [ ] Descending Stairs |  |  |

Date your pain began?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any of the following performed?

X-rays [ ] Yes [ ] No CT scan [ ] Yes [ ] No

EMG/NGC [ ] Yes [ ] No MRI [ ] Yes [ ] No

Arthrogram [ ] Yes [ ] No Injections [ ] Yes [ ] No

Based on the drawing below please indicate your pain level: **\_\_\_\_\_\_\_\_\_\_\_\_\_**



Check any of the following that describe your pain: [ ] Sharp [ ] Numb/Tingling [ ] Dull/Aching [ ] Burning

Check any of the following that help alleviate your pain: [ ] Medication [ ] Rest [ ] Sleep

Do you have headaches? [ ] Yes [ ] No

Frequency of headaches: [ ] 1-2 weekly [ ] 2-4 weekly [ ] 4-5 weekly [ ] Daily

Aggravating Symptoms: [ ] Light [ ] Sound [ ] Noise



**CONSENT FOR TREATMENT:**

I hereby give my permission for Premier Comprehensive Physical Therapy Center Inc. to render treatment to me/my dependent. I understand that I will be given all available pertinent information prior to the treatment being rendered. I will be given the opportunity to ask questions and to have them answered to my satisfaction. I understand that I may decline treatment at any time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

SIGNATURE DATE

**CONSENT TO RELEASE/OBTAIN MEDICAL INFORMATION:**

Permission is hereby granted to Premier Comprehensive Physical Therapy Center Inc. to release information to my insurance company, employer, attorney, workers compensation carrier, physician/facility referred to for further treatment and/or my referring/family physician. Permission is hereby granted to any facility where I have previously been treated to release medical records to Premier Comprehensive Physical Therapy Center Inc.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

SIGNATURE DATE

**AUTHORIZATION FOR PAYMENT OF BENEFITS:**

I authorize Premier Comprehensive Physical Therapy Center Inc. to bill my health insurance for services rendered. All payments received will be applied to my balance. I will be responsible for all co-pays/co-insurance and deductibles that may apply. Although Premier Comprehensive Physical Therapy Center Inc. will help verify and assist me in understanding my benefits, it is ultimately my responsibility and I will not hold Premier Comprehensive Physical Therapy Center Inc. responsible for any misinterpretation of insurance benefits. I understand that any charges not paid by my insurance company are my responsibility, and are due and payable by me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

SIGNATURE DATE

**MEDICARE PATIENTS ONLY:**

I authorize payment of Medicare benefits to Premier Comprehensive Physical Therapy Center Inc. for services rendered, and I authorize the release of medical information to CMS (Centers for Medicare and Medicaid Services)

and/or its agents.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

SIGNATURE DATE