

LAKE CONROE PHYSICAL THERAPY PATIENT DATA SHEET

First:

MI:

Last:

Date of Birth:

Age:

Gender: Male ☐ Female ☐

Physical Address:

Mailing Address:

Phone Numbers:

OK To Call

Best Time To Call

Home: ☐ ☐

Work: ☐ ☐

Cell: ☐ ☐

May we send you text messages for your appointment reminders to the number(s) listed above? ☐ Yes ☐ No

May we send you text messages for Marketing Materials, including Patient review requests to the number(s) listed above? ☐ Yes ☐ No

By marking "Yes" above, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information

May we send you emails relating to your care with us? ☐ Yes ☐ No

By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.

Email:

Preferred language: **Interpreter required?** ☐ Yes

Date of Injury: **Referring Physician:**

Injury Area: **Auto or Work Accident:** ☐ Auto ☐ Work ☐ N/A

State Where Accident Occured:

Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc) in the last 60 days? ☐ Yes ☐ No

Are you currently receiving or have you received other therapy services in the last 60 days? ☐ Yes ☐ No

Marital Status:

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Student Status:

☐ Full-Time ☐ Part-Time ☐ None

EMPLOYMENT STATUS

Employment Status:

☐ Active Military ☐ Full-Time ☐ None ☐ Part-Time ☐ Retired ☐ Self Employed

Employer: _____ Occupation: _____

Address: _____

Phone: _____

Employer: _____ Occupation: _____

Address: _____

Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder's Name: _____ Holder's Birth Date: _____

Policy or Certificate #: _____ Group #: _____

Policy Holder's Employer: _____

Secondary Insurance: _____

Policy Holder's Name: _____ Holder's Birth Date: _____

Policy or Certificate #: _____ Group #: _____

Policy Holder's Employer: _____

How did you hear about us?

- | | | |
|---|---|---|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Hospital | <input type="checkbox"/> Marketing Ad - Print |
| <input type="checkbox"/> Employer | <input type="checkbox"/> Cross Referral | <input type="checkbox"/> Marketing Ad - TV |
| <input type="checkbox"/> Case Manager | <input type="checkbox"/> Friend - Word of Mouth | <input type="checkbox"/> Marketing Ad - Billboard |
| <input type="checkbox"/> Former Patient | <input type="checkbox"/> Attorney | <input type="checkbox"/> Marketing Ad - Direct Mail - Email |
| <input type="checkbox"/> Adjustor | <input type="checkbox"/> Self | <input type="checkbox"/> Marketing Ad - Facebook |
| <input type="checkbox"/> School | <input type="checkbox"/> Screens - Open Houses | <input type="checkbox"/> Marketing Ad - Other _____ |

Specify if other : _____

Note: Please provide us with the most updated information below.

EMERGENCY AND OTHER CONTACTS

| Name | Phone | Work | Cell | Fax | Type |
|------|-------|------|------|-----|------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

Name Relationship

Name Relationship

Signature of Patient

Date

PATIENT INTAKE AND CONSENT FORM

Internal Use Only: A/C# Name A/C Type Office #

CONSENT TO TREATMENT

I consent to rehabilitation and related services at: LAKE CONROE PHYSICAL THERAPY

In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. Initials: _____

TREATMENT OF MINORS

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. Initials: _____

LIABILITY

I know and agree that: LAKE CONROE PHYSICAL THERAPY is not responsible for loss or damage to personal valuables. Initials: _____

WAIVER AND RELEASE

I hereby release, discharge and acquit: LAKE CONROE PHYSICAL THERAPY its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. Initials: _____

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to: LAKE CONROE PHYSICAL THERAPY
I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. Initials: _____

FINANCIAL POLICY

I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

To assist in establishing your account, please:

- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information.
- Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf.

Initials: _____

NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS

I acknowledge receipt of Notice of Privacy Practices.

Initials: _____

I acknowledge receipt of the Statement of Patient Rights.

Initials: _____

I certify that all of the information provided herein is true and correct.

Patient/Guardian
Signature _____

Witness
Signature _____

Date _____

Medical History Form

| | | | |
|--|---|---|------|
| Patient Name: | | Today's Date: | |
| Referring Physician: | | Date of Birth: | Age: |
| Primary Care Physician: | | Date of Injury or Onset: | |
| Date of Next Physician Appointment: | | | |
| Reason for Therapy: | | | |
| Cause of Injury or Onset: <input type="checkbox"/> Accident <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Other: If Other, please explain: | | | |
| Have you been hospitalized for the present condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, date: | | | |
| Did you have surgery for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, date: If Yes, surgery type: | | | |
| Are you currently receiving any other care for the condition mentioned above? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe: | | | |
| Have you ever received therapy in the past for the condition mentioned above? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, date: Describe previous treatment: | | | |
| Previous Treatment: <input type="checkbox"/> Successful <input type="checkbox"/> Unsuccessful | | | |
| Have you fallen in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, how many times? If Yes, were you injured? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you feel unsteady when standing or walking? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you worry about falling? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| What are your personal goals/outcomes you hope to achieve from therapy? | | | |
| Describe your general health: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor | | Do you smoke or use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply) | | | |
| <input type="checkbox"/> Allergies <input type="checkbox"/> Latex <input type="checkbox"/> Other | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Problems | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy or Seizure Disorder | <input type="checkbox"/> Metal Implants | |
| <input type="checkbox"/> Anxiety or Panic Disorders | <input type="checkbox"/> Fainting | <input type="checkbox"/> MRSA | |
| <input type="checkbox"/> Arthritis <input type="checkbox"/> OA <input type="checkbox"/> RA | <input type="checkbox"/> Fatigue or Weakness | <input type="checkbox"/> Multiple Sclerosis | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fever or Chills | <input type="checkbox"/> Nausea / Vomiting | |
| <input type="checkbox"/> Use of Blood Thinners | <input type="checkbox"/> Fractures | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Bowel or Bladder Disorder | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Head Injury or Concussion | <input type="checkbox"/> Parkinson's Disease | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Peripheral Vascular Disease | |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Heart Disease or Heart Attack | <input type="checkbox"/> Respiratory or Breathing Problems | |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | <input type="checkbox"/> Ringing in Ears | |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Hernia | <input type="checkbox"/> Sexual Dysfunction | |
| <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Blood Pressure <input type="checkbox"/> High <input type="checkbox"/> Low | <input type="checkbox"/> Skin Abnormalities | |
| <input type="checkbox"/> Deep Vein Thrombosis (DVT) | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Stroke or TIA | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Thyroid Problems | |
| <input type="checkbox"/> Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II | <input type="checkbox"/> Hypersensitivity to Hot or Cold | <input type="checkbox"/> Tuberculosis | |
| List any other medical problems and explain: | | | |

Medical History Form

Medication List

| Name of Medication | Dosage | Frequency | |
|--|--------|-----------|---|
| <input type="checkbox"/> Check Box if Medication List provided separately. | | | |
| 1. | | | <input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other |
| 2. | | | <input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other |
| 3. | | | <input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other |
| 4. | | | <input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other |
| 5. | | | <input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other |
| 6. | | | <input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other |
| 7. | | | <input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other |
| 8. | | | <input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other |
| 9. | | | <input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other |
| 10. | | | <input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other |
| 11. | | | <input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other |
| 12. | | | <input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other |

Over the Counter Medications (check all that apply): ☐ Aspirin/Ibuprofen ☐ Antacids ☐ Sleeping Aids ☐ Cold Medicine:
☐ Cough Medicine ☐ Allergy Relief ☐ Laxative ☐ Diet Pills ☐ Vitamins/Herbal Supplements ☐ Other:

Pain Scale

Rate the severity of your pain by circling a box on the following scale.

No Pain

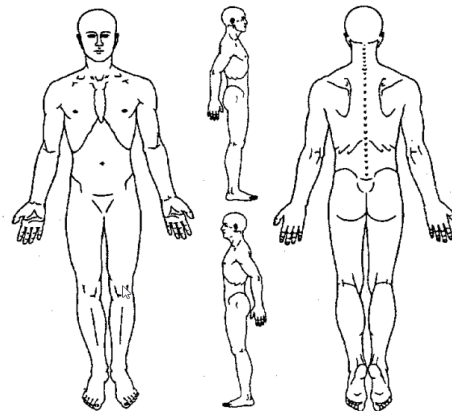
Worst Pain

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|----|

On the Body Diagram mark where you are experiencing symptoms, right now. Use the letters below to indicate the type and location.

KEY:

A = Aching B = Burning N = Numbness
P = Tingling S = Stabbing O = Other



Signature of Patient:

DOB:

Printed Name of Patient:

Date: