Welcome to Woodbury Physical Therapy

Patient Information

Thank you for choosing Woodbury Physical Therapy for your health care needs. Please complete this form in ink.
If you have any questions or concerns, please do not hesitate to ask for assistance.

(please print clearly) Date: _____

Name: (Mr. Mrs. Ms Dr.) _____ SS/HIC/Patient ID #: _____
First Middle Initial Last

Address: _____ City: _____ State: _____ Zip Code: _____

Mailing address if different: _____

Sex: ❑ Female ❑ Male Birthdate: _____ E-mail: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Cell ❑ No Preference

❑Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered # of Children ____

Patient Employer/School: _____Occupation: _____

Employer/School Address: _____ City: _____ State: _____ Zip Code: _____

Spouse or parent's name: _____ Employer: _____ Work Phone: (_____)_____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency: _____ Phone: (_____)_____

Symptoms

Reason for visit: _____

_____

How serious do you think your problem is? ❑ Annoying ❑ Mild Limitations ❑ Severe Limitations ❑ Can't Function

Other complaints: _____

When did you first notice the symptoms? _____ Have you had similar conditions in the past? Y N

Is the condition getting progressively worse? _____ Where specifically is the problem(s) located? _____

Which activities are difficult to perform? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down ❑ Other

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

Rate the severity of your pain. (1 = mild pain or discomfort, to 10 = severe pain) 1 2 3 4 5 6 7 8 9 10

❑ Constant ❑ Comes and goes: ❑ 0-25% ❑ 26-50% ❑ 51-75% ❑ 76-100% of the time

How has this problem affected your life?

1) Difficulty in performing basic activities: ❑ Bathing ❑ Showering ❑ Shaving ❑ Dressing ❑ Sleeping ❑ Eating

2) Daily duties, difficulty in performing: ❑ Cleaning ❑ Washing Dishes ❑ Sweeping/Mopping

3) Hobbies, slowing or prevention of certain hobbies/recreation: _____

4) Work: ❑ I Just Get Through = Slower Production Due to Pain ❑ Cannot work at all since _____

5) Family/Social: ❑ Not as Easy Going ❑ Grumpy Feeling Due to Pain ❑ Depression/Angry due to pain

What activity would you like to be able to do again that is difficult or you cannot do now? _____

CONFIDENTIAL

...continued on next page

Is this a new or an aggravation of an old problem? _____

Trauma from birth to present, please list by date and describe:

1) Injuries and falls: _____

2) Broken bones: _____

3) Car/Bike accidents: _____

Do you have any metal in your body? ❑ Yes ❑ No If yes, where? _____

Have you had any previous Physical Therapy? ____ Therapists Name/address/phone: _____

_____

What treatment have you received for your condition?

❑ Now on medication ❑ Surgery ❑ Physical Therapy ❑ Other _____

Recent MRI's, X-Rays, CT Scans or any other Diagnostic Testing? Date/where taken: _____

Name and address of other doctor(s) who have treated you for your condition: _____

_____

Family Dr/PCP name address phone number: _____

Date of last physical: _____

Health History *Check only those conditions which are applicable:*

❑ AIDS/HIV	❑ Cataracts	❑ Hepatitis	❑ Mumps	❑ Stroke
❑ Alcoholism	❑ Chemical Dependency	❑ Hernia	❑ Osteoporosis	❑ Suicide Attempts
❑ Allergy Shots	❑ Chicken Pox	❑ Herniated Disc	❑ Pacemaker	❑ Thyroid Problems
❑ Anemia	❑ Depression	❑ Herpes	❑ Parkinson's Disease	❑ Tonsillitis
❑ Anorexia	❑ Diabetes	❑ High Blood Pressure	❑ Pinched Nerve	❑ Tuberculosis
❑ Appendicitis	❑ Emphysema	❑ High Cholesterol	❑ Pneumonia	❑ Tumors, Growths
❑ Arthritis	❑ Epilepsy	❑ Kidney Disease	❑ Polio	❑ Typhoid Fever
❑ Asthma	❑ Fractures	❑ Liver Disease	❑ Prostate Problems	❑ Ulcers
❑ Bleeding Disorders	❑ Glaucoma	❑ Measles	❑ Prosthesis	❑ Vaginal Infections
❑ Breast Lump	❑ Goiter	❑ Migraine Headaches	❑ Psychiatric Care	❑ Venereal Disease
❑ Bronchitis	❑ Gonorrhea	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Whooping Cough
❑ Bulimia	❑ Gout	❑ Mononucleosis	❑ Rheumatic Fever	❑ Other _____
❑ Cancer	❑ Heart Disease	❑ Multiple Sclerosis	❑ Scarlet Fever	_____

Dates of last exams: _____

(Woman) Are you pregnant? ❑Yes ❑No Nursing? ❑Yes ❑No Taking Birth Control Pills? ❑Yes ❑No

List any types of surgeries which you have had and the dates which they occurred: _____

_____

Previous accidents/ Auto/Workers Comp/Personal: _____

Date/type of injury: _____

Please list all medications you are currently taking: _____

Allergies/Age of mattress: _____

Daily Habits

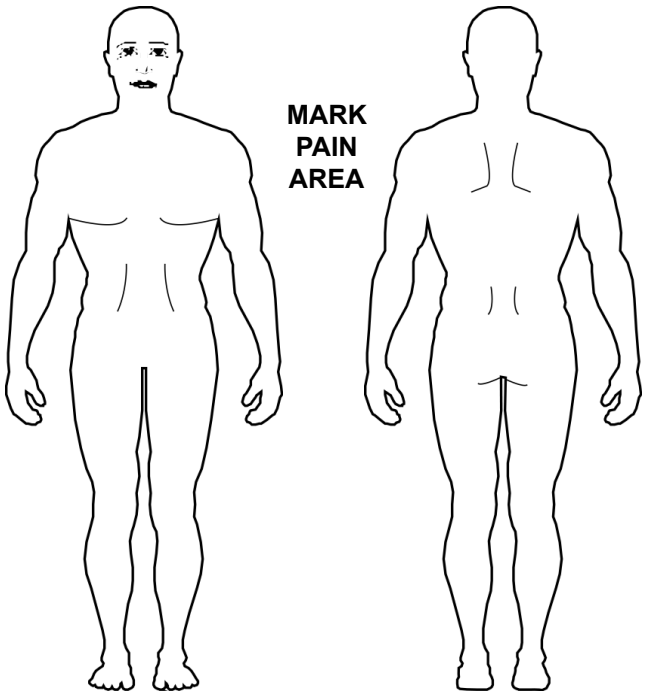
What type of exercise do you perform on a daily basis? ❑ None ❑ Moderate ❑ Heavy

What do your daily work habits include? _____

What vitamins do you currently take? _____ Nutritional supplements (if any)? _____

Do you smoke? ❑ Yes ❑ No How much per day? _____

How much liquor do you consume weekly? _____ How many caffeinated beverages do you consume daily? _____



MARK PAIN AREA

+++ Burning **000 Stabbing**
--- Sharp **III Consistent**

Additional details can be provided below

_____
_____
_____
_____
_____
_____
_____

Insurance Information

Name of insured: _____ Relationship to patient: _____

Birthdate: _____ Social Security#:: _____ Date employed: _____

Name of employer: _____ Work Phone: (_____)_____

Address: _____ City: _____ State: _____ Zip Code: _____

Insurance Co.: _____ Phone: (_____)_____

Group #: _____ Employer #: _____

Insurance Co. address: _____ City: _____ State: _____ Zip Code: _____

How much is your deductible/copay? _____ How much have you used? _____ Max. annual benefit? _____

Do you have additional insurance? ❑ Yes ❑ No **If Yes, please complete the following:**

Name of insured: _____ Relationship to patient: _____

Birthdate: _____ Social Security#:: _____ Date employed: _____

Name of employer: _____ Work Phone: (_____)_____

Address: _____ City: _____ State: _____ Zip Code: _____

Insurance Co.: _____ Phone: (_____)_____

Group #: _____ Employer #: _____

Insurance Co. address: _____ City: _____ State: _____ Zip Code: _____

Responsible Party

Name of person responsible for this account: _____

Relationship to patient: _____ Phone: (_____)_____

Address: _____ City: _____ State: _____ Zip Code: _____

Name of employer: _____ Work Phone: (_____)_____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Woodbury Physical Therapy all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Woodbury Physical Therapy may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Physical Therapy Office will prepare any necessary reports and forms to assist me in making collection from the Insurance Company. However, I clearly understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

_____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Family Health Information

Name	Relation	Past/Present Health Problems