KATE SCHWARTZ PHYSICAL THERAPY, LLC

PATIENT RECORD FORM AND AGREEMENT

DATE________________________DATE OF INJURY______________________ DATE OF BIRTH____________________

PATIENT'S NAME____MALE/FEMALE______________________

____

ADDRESS CITY STATE ZIP

PHONE: HOME_______________________________WORK______________________CELL______________________

PRIMARY CARE DOCTOR________________________________REFERRING DOCTOR_________________________

HAVE YOU HAD PHYSICAL THERAPY IN THE PAST? _______________WHEN?_______________________________

Chiropractic – Occupational Therapy – Speech? ________________________________WHEN?____________________

SOCIAL SECURITY NUMBER (for billing purposes)____

EMPLOYER_______________________________________EMPLOYER PHONE_________________________________

EMPLOYER ADDRESS____ OCCUPATION: __________________________

IS PRIMARY INSURANCE AUTO INSURANCE?__________________ WORKMAN'S COMP?____________________

DO YOU HAVE AN ATTORNEY INVOLVED WITH YOUR INJURY?____

IF YES, PLEASE LIST NAME, ADDRESS, and PHONE ____

____

PRIMARY INSURANCE CO.______________________________SUBSCRIBER'S NAME: __________________________

SUBSCRIBER'S DATE OF BIRTH__________________RELATIONSHIP TO SUBSCRIBER______________________

SECONDARY INSURANCE COMPANY____

ARE YOU AWARE OF YOUR PHYSICAL THERAPY BENEFITS ?____

IF NO, PLEASE INQUIRE WITH ADMINISTRATIVE STAFF

PLEASE NOTE, $40.00 WILL BE BILLED TO YOUR ACCOUNT IF OUR OFFICE IS NOT NOTIFIED OF YOUR CANCELLATION WITHOUT 24 HOURS NOTICE.

DO YOU UNDERSTAND THIS FINANCIAL RESPONSIBILITY ? ____

Your medical insurance contract is between you and your carrier. Our office will submit claims to your insurance carrier. You are responsible for any copay, coinsurance, deductible, medical supplies or modality not covered by your insurance company. **Copay is due each visit**. Referrals & authorizations for Physical Therapy are the patient's responsibility.

I understand I am responsible for all bills incurred while receiving physical therapy, including those charges not covered by my insurance. I authorize the use of this form on all insurance submissions. I authorize release of information to all my insurance cos. I authorize my physical therapist to act as my agent in helping me obtain payment from my insurance co. I authorize payment direct to my physical therapist. I permit a copy of this authorization to be used in place of the original.

Please refrain from using strong perfumes/colognes and use of all phones during treatment sessions.

***May we contact you and/or leave messages about your appointments at phone numbers listed?** _______________

SIGNATURE:____DATE: ___________________________

Name: ________________________ D.O.B. ____________________ Date: _______________

Height:__________ Weight:______________ Age:______________ R/L Handed:________________

Occupation and/or school:____

Describe your problems/pain beginning with the most bothersome to the least:

1)____

2)____

3)____

Please list operations/surgeries you've had and include dates:

____

____

____

Please list any medications you are currently taking:

____

____

How did the present pain or injury begin? ____

____

When? ____

Have you had any special tests done? X-rays, MRI, CT Scan, EMG, other?

____

Where is your pain/symptoms?____

____

Are symptoms getting worse, getting better or staying the same? ____________________________

What specifically increases your pain?____

What specifically decreases your pain?____

Are your symptoms constant? _________ intermittent? ___________ Related to Activity? ________

What is your pain intensity from best to worst? (rating 1-10)?

(No pain)____(Most pain)

best average worst

Have you had anything like this before?

Explain____

____

Are you currently working? (please circle):

full-time part-time modified duty unemployed disability retired

Days missed at work because of injury?____________________ Out of Work Date?____________

Are there any restrictions set by your doctor? yes no Explain:______________________________

How does the problem interfere with your ability to work? __________________________________

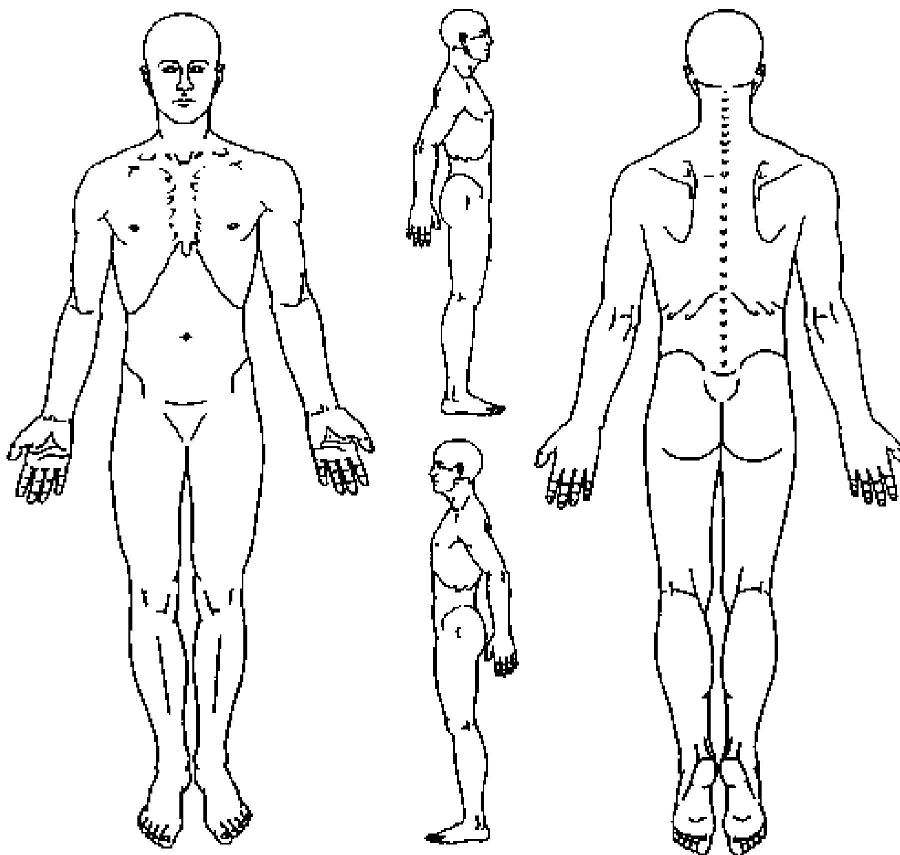
Please state the maximum amount of time you tolerate each of the following activities:

Sitting ________ Standing ________Walking ______Driving _________Passenger Driving ________

How are you at night? _____________ morning? ____________ late in the day? ________________

PLEASE INDICATE ON THE DRAWING BELOW THE LOCATION OF YOUR SYMPTOMS

P – Pain N – Numbness T- Tingling B – Burning A - Achiness



Please check as many of the following health problems that you now have or have had:

Anemia or Blood Disease ___
Heart Trouble/Murmur ___
High Blood Pressure ___
Chest Pain/Angina ___
Shortness of Breath ___
Lung Disease ___
Allergy/Hay Fever/Asthma ___
Eye Trouble ___
Deafness/Ear Trouble ___
Major Illness ___
Varicose Veins/Leg Sores ___
Cancer/Tumor/Cyst ___
Bone/Joint Disease ___
Back/Disc problems ___
Amputation Foot/Leg/Arm ___
Multiple Sclerosis ___
Head Injury ___
Seizures/Epilepsy ___
Chronic Osteomylitis ___
Phlebitis ___
Pacemaker ___
Fibromyalgia ___

Stomach/Intestinal Trouble ___
Liver/Gallbladder Disease ___
Hernia ___
Diabetes/Thyroid Disease ___
Sugar/Protein in Urine ___
Kidney/Bladder Trouble ___
Headaches/Migraine ___
Dizziness/Fainting ___
Nervousness/Mental Illness ___
Paralysis/Nerve Disease ___
Broken Bones ___
Joint or Back Injury ___
Arthritis/Bursitis/Ganglion ___
Recent Weight Loss/Gain ___
Loss of Sight ___
Cerebral Palsy ___
Parkinson's Disease ___
Stroke ___
Tuberculosis ___
Hardening of Blood Vessels ___
Osteoporosis ___
Anxiety/Depression ___

Smoker (Y/N) ________
How much day ________
How long (yrs) ________

Do you drink Alcohol? __
Beer/Wine? ____________
How much day/wk? ____

Do you exercise regularly
(at least 3 times a week)
YES NO
Doing what? ___________

Are you pregnant now? __
Ages of children _______
(if any)

Describe your major medical problems: ____
____