Patient Information

First:	Middle:	Last:	
Address:			
City:	State:	Zip:	Today's Date:
SSN:	Birth date:	Sex:	Marital Status:
Home Phone:	Work Phone:		Date of last Dr. Visit:
Cell Phone:	Work Related:	Accident Related:	Date Injured:
Doctor:	Referrral Source, if different from doctor:		
Person responsible for account:			
Address:			Occupation:
City:	State:	Zip:	Work Phone:
Employer's Name:			
Employer's Address:			
Friend or Relative not living with you:			Phone:
Lawyer's name and address:			
Primary Insurance:	Insurance Address:		
Policy Holder's Name:			DOB:
Group #:	Claim #:	SS#/ID#:	Phone:
Secondary Insurance:	Insurance Address:		
Group #:	Claim #:	SS#/ID#:	Phone:
In case of Emergency, Notify:	Relation:		Phone:

Welcome to Blackfoot Physical Therapy! In consideration of services rendered for the above patient, I hereby assign to BLACKFOOT PHYSICAL THERAPY the release of all information necessary to process insurance claims. I understand that I am responsible for the amount my insurance or responsible party does not pay. I further understand that it is my responsibility to keep my account up to date if payment is not received within 60 days and if this is not done I agree to pay any collection or attorney's fees as well as all interest accrued at 1.5% per month due to my delinquency. I also hereby consent to have Blackfoot physical therapy provide me with physical therapy services.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand this notice.

Please check the box to acknowledge the above statement. ☐

I request that payment of authorized insurance benefits including Medicare or Medicaid benefits be made either to me or on my behalf to Blackfoot Physical Therapy for any services furnished me by that institution. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Please check the box to acknowledge the above statement. ☐

Patient Medical History

Have you been seen by your doctor or other healthcare providor for this condition? Yes: ☐ No: ☐

Date first seen for this injury: _____ By whom? _____

Have you had surgery for this injury? Yes: ☐ No: ☐ Number of surgeries: _____

Type of surgery: _____

List your **current** prescription or non-prescription medications:

Name	Dosage	Freqency	Route	Name	Dosage	Freqency	Route

Have you had any of the following medical or rehabilitative services for this injury or episode?

	Yes	No		Yes	No
Physical Therapy	___	___	MRI	___	___
Massage Therapy	___	___	X-Rays	___	___
Chiropractic	___	___	CT Scan	___	___
Podiatrist	___	___	EMG/NCV	___	___
Neurologist	___	___	Myelogram	___	___
Orthopedist	___	___	Injections	___	___
Other _____					

Have you EVER had ANY of the following?

	Yes	No		Yes	No
Asthma, Bronchitis, Emphysema	___	___	Severe or frequent headaches	___	___
Shortness of breath/chest pain	___	___	Numbness or Tingling	___	___
High Blood Pressure	___	___	Dizziness or Fainting	___	___
Epilepsy/Seizures	___	___	Bowel or Bladder Problems	___	___
Thyroid disease or Goiter	___	___	Weakness/Energy loss	___	___
Anemia	___	___	Weight loss/gain	___	___
Diabetes/Type _____	___	___	Any pins or metal implants	___	___
Arthritis / Where _____	___	___	Emotional/Psychological	___	___
Osteoporosis	___	___	Are you pregnant?	___	___
Sleeping difficulties	___	___	Do you smoke?	___	___

Have you EVER had ANY of the following?

	Yes	No		Yes	No
Coronary heart disease or Angina	___	___	Vision or Hearing Difficulties	___	___
Do you have a pacemaker	___	___	Hernia	___	___
Heart Attack/Surgery	___	___	Varicose veins	___	___
Stroke/TIA	___	___	Joint replacement surgery	___	___
Congestive heart disease	___	___	Neck injury/surgery	___	___
Blood clot/Emboli	___	___	Back injury/surgery	___	___
Infectious Disease	___	___	Shoulder injury/surgery	___	___
Cancer/Type _____	___	___	Knee injury/surgery	___	___
Gout	___	___	Elbow/hand injury/ surgery	___	___
Allergies	___	___	Ankle/foot injury	___	___

Do you feel you have been made aware of your diagnosis? Yes ☐ No ☐

Any other information that would assist us in your care:

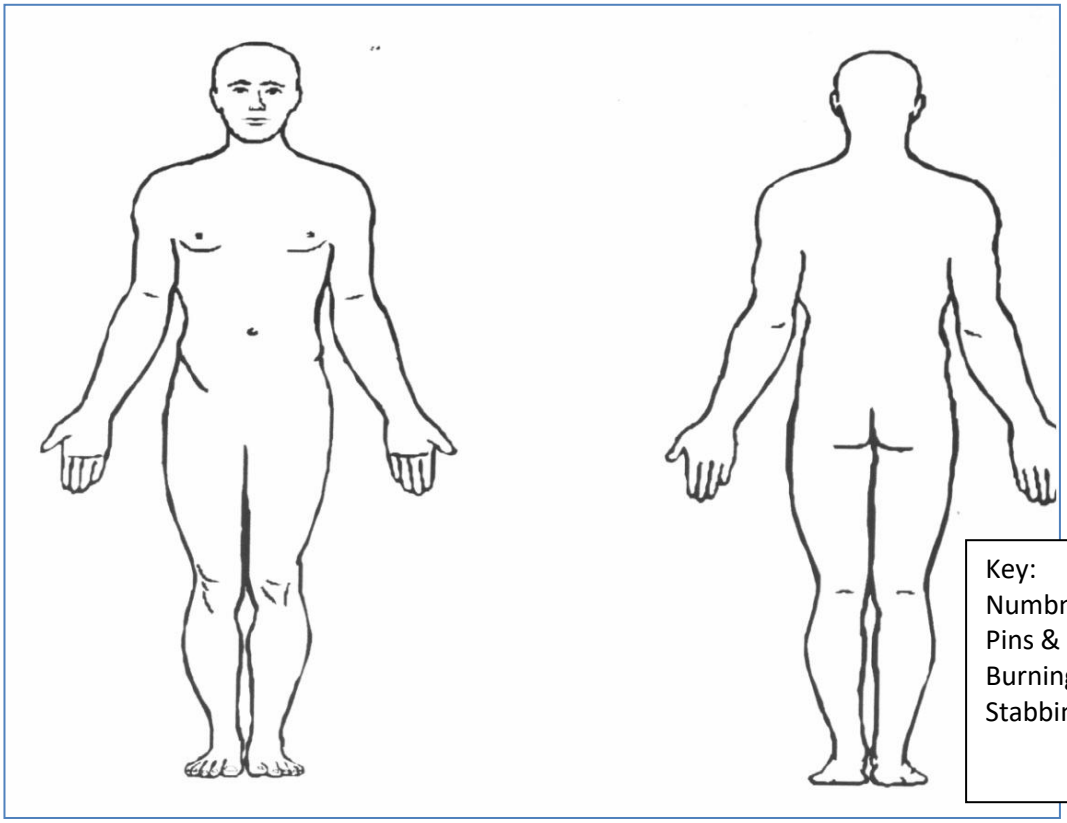
What is your Height?: _____ What is your current Weight?: _____

	Yes	No
Would you allow a student physical therapist to take part in your evaluation/treatment	___	___
Do you participate in any sports, exercise programs, or activities on a regular basis?	___	___
Have you fallen 2 or more times in the last year?	___	___
Have you had ANY falls in the last year that resulted in an injury?	___	___

If you are having pain, please rate the intensity of your pain on a scale of 0 to 10 with 0 being no pain, and 10 being the worst pain possible.

_____

Please indicate where your symptoms are located.



Key:
Numbness==========
Pins & Needlesooooooooooo
Burning Painxxxxxxxxxxx
Stabbing Pain////////////////////

Based on your awareness, what are your goals and expectations from physical therapy?

_____

_____

_____

_____ _____ _____ _____

Patient's Signature Date Signature of Guardian if patient is a minor Date

_____ _____

Therapist's Signature Date