Patient Information Form

Date _______________ Patient # ____________

Name _________________________________ Date of Birth____________ Age_____ SS#________________

Address______________________________________City________________State______ Zip Code________

Home Phone________________________________ Cell Phone___________ Sex____ Marital Status_________

E-mail Address____

Occupation____________________________ Business Name____

Business Address____ Business Phone___________________

Does your work expose you to any of the following? ☐ Stress ☐ Heavy Lifting ☐ Hazardous Substances

Date of Injury______________________ How did injury occur? ____

Injury Area____ Post-OP_______________________

Primary Insurance____ Insurance ID#_______________________

Primary Holder Name____ D.O.B.____________________

Insurance Address____ Insurance Phone_______________

Secondary Insurance______________________________________ Insurance ID#______________________

Insurance Address____

Insurance Phone________________________________ Policy/Group #_________________________________

Primary Doctor____ Primary's phone__________________________

Emergency Contact Name_____________________________________ Phone Number_____________________

Race: ☐ White ☐Black/African American ☐ Asian ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Primary Language**: ____

How Did You Hear About Us? Friend Hospital TV Doctor PT Center Newspaper Other______________

Have you received any outpatient physical or speech therapy in this calendar year? ______ If yes, when?_______________________________ where?____________________________________

Have you received any outpatient occupational therapy in this calendar year? ______ If yes, when?_______________________________ where?____________________________________

MEDICAL/SOCIAL HISTORY

With whom do you live?

☐ Alone ☐ Spouse only

☐ Spouse and children

☐ Children only ☐ Other relatives

☐ Other ______________________________

Smoke Free? ☐ Yes ☐ No

Where do you live?

☐ Private home; **CIRCLE ONE 1 level/2 level**

☐ Apartment; **CIRCLE ONE Lower/Upper Level**

☐ Assisted living/ group home

☐ Other ______________________________

Does your home have: Check all that apply

☐ Stairs, no railing ☐ Stairs, railing

NUMBER OF STEPS & LOCATION

____

☐ Ramps ☐ Elevator

☐ Assistive devices ______________________

☐ Obstacles ____________________________

Do you use:

☐ Cane ☐ Glasses

☐ Walker ☐ Hearing aids

☐ Wheelchair ☐ Incontinence Products

Is there any chance that you are currently pregnant?

☐ Yes ☐ No

Within the past year, have you had any of the following symptoms?

☐ Chest pain

☐ Heart palpitations

☐ Shortness of Breath

☐ Dizziness or blackouts

☐ Coordination problems

☐ Weakness in arms or legs

☐ Loss of balance

☐ Difficulty walking

☐ Joint pain or swelling

☐ Pain at night

☐ Difficulty sleeping

☐ Loss of appetite

☐ Nausea/ vomiting

☐ Weight loss/ gain

☐ Incontinence

☐ Bladder, bowel or bathroom issues

☐ Other _________________

Please check if you have ever had:

☐ Arthritis
☐ Broken bones, fractures
☐ Osteoporosis
☐ Blood disorders
☐ Circulation/vascular disorder
☐ Heart problems
☐ Pacemaker
☐ High blood pressure
☐ Lung problems
☐ Stroke
☐ Diabetes/high blood sugar
☐ Low blood sugar/hypoglycemia
☐ Head injury
☐ Multiple sclerosis
☐ Muscular dystrophy
☐ Parkinson’s disease
☐ Seizures/ epilepsy
☐ Developmental/growth disorders
☐ Thyroid problems
☐ Cancer TYPE __________________
☐ Infectious disease
☐ Kidney problems
☐ Ulcers/ stomach problems
☐ Skin diseases
☐ Depression
☐ Other___________________

Have you ever had surgery?

☐ Yes ☐ No

Surgery Date AND Type

____

____

____

Do you take prescription medications?

☐ Yes ☐ No

If yes, please list ____________________________________

____

____

____

____

Allergies? ____

____

Do you take any non-prescription medication? ☐ Yes ☐ No

☐ Advil/Aleve
☐ Ibuprofen/ Naproxen
☐ Aspirin
☐ Tylenol
☐ Other __________________

Are you a smoker? ☐ Yes ☐ No

Within the past year, have you had any of the following tests?

☐ Arthroscopy
☐ Biopsy
☐ Blood tests
☐ Bone scan
☐ CT scan
☐ Doppler ultrasound
☐ Echocardiogram
☐ EMG
☐ EKG
☐ MRI
☐ Myelogram
☐ Nerve conduction velocity
☐ Pulmonary function
☐ Stress test
☐ X-rays
☐ Other: ___________________

I certify that all of the information on this intake form is true and correct to the best of my knowledge and that I understand the policies of FirstCare Physical Therapy. I give my consent to receive any and all treatment that is rendered at FirstCare Physical Therapy. I am responsible for notifying the Center of any changes in my health or billing information. I give consent for the Center to bill my insurance company and for assignment of direct payment to the Center by my insurance company. The Center will make every effort to collect payment from my insurance company, however I understand that regardless of my account status, I am ultimately responsible for all charges incurred for professional services rendered at FirstCare Physical Therapy to the extent that the law allows.

Signature____Date______________________

I authorize the release of any all information in your possession, custody, and control, including x-rays, medical records, and emergency room records and test reports. The undersigned expressly authorizes the release of my complete hospital/physician’s office chart to FirstCare Physical Therapy. I also give consent for the Center to release their records, within the guidelines of the law, as necessary to my physician, insurance company, rehab nurse/case manager or attorney.

Signature____Date______________________