



Name: _____ Age: _____ Height: _____ Weight: _____

PRESENT INJURY/ILLNESS

How did the injury occur? _____

If due to illness, when did symptoms begin? _____

Date of injury/onset _____ Was onset gradual? Yes _____ No _____

Was surgery performed for present problem? Yes _____ No _____ If yes, answer the following:

Date of surgery _____ Surgeon _____ Location of surgery _____

Please list all symptoms beginning with CHIEF complaint: _____

What aggravates symptoms? _____

What helps relieve symptoms? _____

Is medication being taken for this condition? Yes _____ No _____ If yes, please list on medication sheet

Does it help condition? Yes _____ No _____

Has treatment been received for this injury previously? Yes _____ No _____ If yes, answer the following:

When? _____ Where? _____

By Whom? _____

Type of Treatment _____

CHECK ALL STATEMENTS THAT APPLY TO CURRENT CONDITION

- Difficulty walking on uneven surfaces.
- Difficulty walking up and down stairs.
- An assistive device is needed to walk.
- Splint or brace is required.
- Difficulty sleeping.
- Difficulty with overhead activities.
- Difficulty lifting, carrying.
- Difficulty with prolonged sitting/standing.
- Difficulty bending over.
- Increased symptoms in the a.m.

PAST MEDICAL HISTORY

- Shoulder separation/dislocation.
- Knee injury.
- Ankle injury.
- Fractures.
- Joint disease.
- Cardiovascular pathology.
- High blood pressure.
- Diabetes.
- Head trauma.
- Other _____

Other than a routine check-up, has treatment been received by a physician, physical therapist, or other medical practitioner within the past 5 years? Yes _____ No _____ If yes, please describe _____

Has physical activity been restricted during the past 5 years? Yes _____ No _____ If yes, explain. _____



HEALTH HABITS

ALCOHOL CONSUMPTION

- On a daily basis. Occasionally Never

SMOKING

- Non – smoker. Less than 1 pack daily. More than 1 pack daily
 Other tobacco product _____ Duration of smoking _____
Have you ever tried to stop smoking? Yes _____ No _____

ARE YOU:

- Frustrated when waiting,
often in a hurry? Impatient when waiting,
occasionally hurried? Comfortable when waiting,
easy going?

STRESS:

- High Moderate Low/None

PHYSICAL/EXERCISE ACTIVITY

NORMAL ACTIVITY LEVEL

- High Moderate Low

FREQUENCY OF EXERCISE

- Daily 2-3x/week None

DURATION OF EXERCISE

- More than 1 hour 1 hour Less than 1 hour

IS STRETCHING PERFORMED

- Before exercise After exercise Never

DOES EXERCISE CAUSE ANY OF THE FOLLOWING:

- Chest pains Irregular heart beat Nausea/dizziness
 Shortness of breath Leg/arm pain Pressure over heart

PLEASE LIST ANY ADDITIONAL IMPEDIMENT THERE MIGHT BE FOR EXERCISING:

COMMENTS: _____



THANK YOU FOR SELECTING OUR HEALTHCARE TEAM. TO HELP US MEET YOUR HEALTHCARE NEEDS, PLEASE FILL OUT THIS FORM COMPLETELY. IF YOU HAVE ANY QUESTIONS OR NEED ASSISTANCE, PLEASE ASK. WE WILL BE HAPPY TO HELP.

PATIENT INFORMATION:

DATE _____

NAME _____
 Last First M.I.

ADDRESS _____
 Street City State Zip Code

HOME PHONE _____ CELL PHONE _____

SOC. SEC.# _____ - _____ - _____ DATE OF BIRTH _____ - _____ - _____

MALE FEMALE SINGLE MARRIED

EMPLOYER _____ OCCUPATION(Previous if retired) _____

ADDRESS _____
 Street City State Zip Code

IN CASE OF EMERGENCY PLEASE CONTACT (Not living with you):

NAME _____ RELATIONSHIP _____

HOME PHONE _____ WORK PHONE _____

PRESENT ILLNESS/INJURY:

REFERRING PHYSICIAN _____ DATE OF INJURY _____

TYPE OF INJURY: work auto sports other BODY PART (S) _____

HAS PHYSICAL THERAPY/CHIROPRACTIC TREATMENT BEEN RECEIVED FOR THIS INJURY

PREVIOUSLY? YES _____ NO _____ If yes, please answer the following: When ? _____

Where? _____ By Whom? _____



SPOUSE AND/OR GUARDIAN INFORMATION:

NAME _____ DATE OF BIRTH ____ - ____ - ____

RELATIONSHIP _____ SOC.SEC.#: ____ - ____ - ____

INSURANCE INFORMATION:

PRIMARY INSURANCE _____ EMPLOYER _____

NAME OF INSURED _____ I.D.# _____ GROUP/CLAIM# _____

ADDRESS _____ PHONE _____
Street City State Zip Code

SECONDARY INSURANCE _____

NAME OF INSURED _____ I.D. # _____ GROUP/CLAIM # _____

ADDRESS _____ PHONE _____
Street City State Zip Code

INSURANCE CLAIMS

Jack D. Close and Associates will process your insurance claims as a courtesy to you in a timely manner, based on information you provide us. In the event any or all of your claims are denied, charges for services rendered become your immediate responsibility. It is your responsibility to be aware of your benefits with your insurance company. Medicare patients without a secondary insurance must be responsible for 20% of charges that are NOT covered by Medicare.

CANCELLATIONS & NO SHOWS

We require a 24 hour notice for cancellations. There is a \$25 charge for appointments not cancelled in a timely manner and for missed appointments. It is your responsibility to pay the cancellation fee.

X _____

AUTHORIZATION AND RELEASE

I authorize the release of any information including diagnosis and the records of any treatments rendered to me or my child during the period of such care to the third party payers and/or other health care practitioners. This will allow Jack D. Close and Associates to bill my insurance company. I authorize and request my insurance company to pay directly to Jack D. Close and Associates Physical Therapy and Rehabilitation Center. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ DATE _____

For your convenience, we offer the following method of payment: cash, personal check, visa/MasterCard.

Thank you for taking the time to fill out this form.



Patient Name: _____

Patient ID#: _____

Date of Service: _____

Service: Physical Therapy

Before your bills can be processed, we need answers to all of the following questions.

1. When did the illness or injury occur? (MM/DD/YY): _____
2. Is this illness due to an MVA: () Yes () No
 - a. If yes, do you have an attorney: () Yes () No
 - b. _____ Attorney Name
3. Where did the illness or injury occur? _____
4. How did the illness or injury occur? _____
5. Is this illness or injury someone else's fault: () Yes () No
Explain? _____
6. Is your illness/injury work related? () Yes () No
(If yes, continue to answer questions 7 and 8.)
7. Did you report the condition to your employer? () Yes () No
If yes, to whom? _____
8. Do you expect to receive or have you been provided with Workers' Compensation Benefits? () Yes () No

Note: Workers' Compensation is not the same as state disability.

This form will be submitted with your claim to your insurance carrier.
Contact your insurance carrier for any questions.

Signature Patient/Guardian: _____ **Date:** _____

Witness: _____ **Date:** _____

NOTE: If additional space is needed, please use the back of this form.

