Close physical therapy

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:_____

_____

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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.

Close physical therapy

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.

PATIENT MEDICATION LIST

Patient Name:

Date:

Medication	Dosage	Times/day