SOUTHSIDE PHYSICAL THERAPY, LLC
at The Wellness Center

MEDICAL HISTORY FORM

Today's Date:___________ Height:___________ Weight: ___________

Name:_______________________________________ Date of Birth:_____________ Male:_________ Female:_________

Address:_______________________________________ City:______________________ State:__________ Zip:________

H ( )_________________________ C ( )_________________________ W ( )_________________________

BEST NUMBER TO REACH YOU? ____________ WOULD YOU LIKE APPT REMINDERS TO YOUR CELL?__________

IF YES, WHAT IS YOUR CELL PHONE PROVIDER/ CARRIER (VERIZON, AT&T, SPRINT)______________________

EMAIL_________________________ Are you pregnant? □ Yes □ No

Emergency Contact: ____ Phone ____________________________________

Allergies:____

Please list any test results (X-ray, MRI, etc):____

Are you currently taking any Medications?: □ Yes □ No

If Yes, please list:____

____

Referring MD:___________________ Phone:___________ Primary Care MD: ________________Phone:___________

Other MD/phone (Please list any other MD who is prescribing or who you are receiving care from):_________________

____

Date of Injury/Onset:________________

Is the reason you are here today due to an auto accident or worker's comp?__________________

If so, please tell our front desk, as there may be other forms to fill out.

Fall Risk Assessment:

1. Have you fallen in the past year? □ Yes □ No Describe:____
2. Did you sustain an injury when you fell? □ Yes □ No Describe:_______________________________________

Do you have any past or present history of:	Yes	No
Heart Disease, High Blood Pressure, Angina, Pacemaker?	_____	_____
Respiratory Problems, Asthma, Allergies, TB?	_____	_____
Diabetes (Any type)?	_____	_____
Arthritis (Diagnosed by M.D.)?	_____	_____
Bone Disease (s)	_____	_____
Skin Disorders, Eczema, Psoriasis, Athlete's foot?	_____	_____
Communicable Diseases, hepatitis, TB?	_____	_____
History of Cancer (Any type)?	_____	_____
Psychiatric history	_____	_____
Any metal or artificial implants?	_____	_____
Any previous injuries to the same area?	_____	_____
Any previous motor vehicle accidents with injuries?	_____	_____
Any previous surgeries?	_____	_____
Any history of neurological conditions? (Seizure, stroke, etc)	_____	_____
Do you have any latex allergies?	_____	_____
Do you have any other medical conditions (please define below)	_____	_____
Do you have a Do Not Resuscitate (DNR) Order?	_____	_____

If you answer yes to any questions please explain below:____

____

____

____

Complaint/ Symptom information

In the diagram on the right, please mark the area(s) where your pain/symptom is located using the following symbols:

X = PAIN
/// = PINS AND NEEDLES
O = NUMBNESS
↓ = SHOOTING PAIN'

List Complaint 1:_________________________________

Please rate your pain right now on a scale of 0 – 10 with 0 being no pain at all and 10 being the worst pain imaginable :

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

What would you rate your pain at its lowest? /10
What would you rate your pain at its highest? /10
What would you rate your current pain? /10

Please describe your pain (circle all that apply).

constant intermittent sharp dull aching burning
tingling stabbing throbbing shooting cramping

List Complaint 2:_________________________________

Please rate your pain right now on a scale of 0 – 10 with 0 being no pain at all and 10 being the worst pain imaginable:

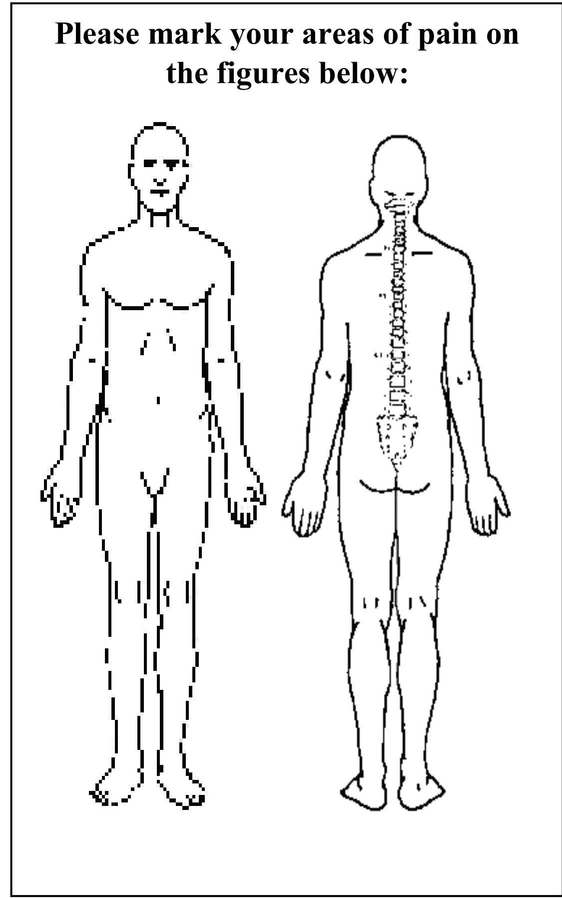
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

What would you rate your pain at its lowest? /10
What would you rate your pain at its highest? /10
What would you rate your current pain? /10

Please describe your pain (circle all that apply).

constant intermittent sharp dull aching burning
tingling stabbing throbbing shooting cramping

Please mark your areas of pain on the figures below:



DO YOU HAVE, OR EVER HAD, ANY DISEASES OR MEDICAL PROBLEMS NOT LISTED? □ Yes □ No

IF SO, PLEASE LIST____

CONSENT OF TREATMENT OF MINOR CHILD (18 AND UNDER)

I hereby authorize Dr. _______________ and whomever he or she may designate as assistance, to administer physical therapy care as he or she deems necessary to my_________________ (indicate relationship to child).

Name of Child: ____ Date: _______________________

Signature of Parent or Guardian:____

Signature of Staff:____ Date: _______________________

FINANCIAL RESPONSIBILITIES

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I authorize payment directly from my insurance company to Southside Physical Therapy. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are ultimately my personal responsibility. I also understand that if I suspend or terminate my care and treatment any fees for professional service rendered me will be immediately due and payable.

If I have insurance, I am responsible for my insurance deductible, co-payments and any service rejected by my insurance company. I am also aware that if I have not made a payment on my outstanding balance within a 30 day period, a service fee of 4 % will be added to my account. If I have an outstanding balance that may be served to a collection agency, there will be an additional fifty dollar fee added.

This office cannot promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, we will pursue on your behalf as far as we are able to. If unsuccessful, you will be expected to take responsibility for any outstanding balance.

I authorize this office to release any information pertinent to my case to any insurance company, adjuster and/or attorney involved in this case, and hereby release this office of any consequences thereof.

Although our office will call to verify your insurance coverage, it is your responsibility to confirm and know your benefits. If you have limited coverage, you are responsible to know when your insurance will stop paying your claims.

I certify that the information provided in this four-part form is correct to the best of my knowledge. I will not hold my doctor or any staff member of Southside Physical Therapy responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient: ____ Date: ____________

Signature of Parent or Guardian: ____Date: ____________

ACKNOWLEDGEMENT AND UNDERSTANDING

I acknowledge and agree to the following:

The Physical Therapist will not be held responsible for any pre-existing medically diagnosed conditions.
Physical Therapy involves the use of different types of physical evaluation and treatment which may be associated with some minor risks and it is your responsibility to be informed about those risks by asking the physical therapist prior to treatment.

Physical therapy is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of Care in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another health care professional who we feel can further assist you.

I hereby authorize the physical therapists and staff affiliated with Southside Physical Therapy to care for my condition as deemed appropriate.

Signature of Patient:____ Date:______________________

Signature of Parent or Guardian:____ Date:_______________________

HIPAA RELEASE FORM

I have read and understand all information regarding:

1. Patient Authorization regarding the privacy notice.

2. Patient Authorization for appointment reminders/scheduling related matters.

3. Patient Authorization regarding physical therapy care being provided in an open adjusting environment.

4. Patient Authorization for contact regarding physical therapy care, related health services and/or related health products.

Your signature indicates your authorization of these activities.

___________________________________ ______________________________ __________
Name Printed Signature Date

If you are a minor, or if you are being represented by another party

__________________________________ ______________________________ __________
Personal Representative Printed Personal Representative Signature Date

____
Description of the authority to act on behalf of the patient

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

PATIENT INFORMATION RELEASE AUTHORIZATION

I, ______________________________________, hereby authorization Southside Physical Therapy, to release information contained in my patient records to the individual(s) and only under the conditions listed below:

1. Name of person(s) to whom information can be disclosed to:

____

____

____

2. Specific type of information to be disclosed:

____

____

____

***PLEASE NOTE THAT THIS AUTHORIZATION RELEASE IS EFFECTIVE UNTIL WRITTEN NOTIFICATION IS RECEIVED BY OUR OFFICE REVOKING AND/OR CHANGING AUTHORIZATION**

____________________________ ____________________________
Patient's Signature Witnessed By

____________________________ ____________________________
Date Signed Date Witnessed

____________________________ ____________________________
Signature of Parent or Guardian Date Signed