



Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phon: \_\_\_\_\_

Referring DR: \_\_\_\_\_ Primary DR: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_ Employer: \_\_\_\_\_

Body Part: \_\_\_\_\_ Date Of Injury/Onset : → \_\_\_\_ / \_\_\_\_ / \_\_\_\_ ←

Surgery Related to Physical Therapy Referral \_\_\_\_\_ Date of Surgery → \_\_\_\_ / \_\_\_\_ / \_\_\_\_ ←

List any medications you are currently taking (Use back or supply list if necessary): \_\_\_\_\_

Have you had any Diagnostic or Rehabilitative Services for this injury? MRI X-Rays Other: \_\_\_\_\_

Check if you have any of the following?

- |                                 |       |                                  |       |
|---------------------------------|-------|----------------------------------|-------|
| Asthma, Bronchitis or Emphysema | _____ | →Do you have a Pacemaker←        | _____ |
| Shortness of Breath/Chest Pain  | _____ | Heart Attack/Surgery             | _____ |
| Coronary Heart Disease          | _____ | Stroke/TIA                       | _____ |
| High Blood Pressure             | _____ | Blood Clot/Emboli                | _____ |
| Epilepsy/Seizures               | _____ | Thyroid Trouble/Goiter           | _____ |
| Anemia                          | _____ | Infectious Disease               | _____ |
| →Diabetes←                      | _____ | Cancer or Chemo/Radiation        | _____ |
| Arthritis/Swollen Joints        | _____ | Osteoporosis                     | _____ |
| Varicose Veins                  | _____ | Gout                             | _____ |
| Sleeping Difficulties           | _____ | Emotional/Psychological Problems | _____ |
| Bowel or Bladder Problems       | _____ | Severe/Frequent Headaches        | _____ |
| Vision/Hearing Difficulties     | _____ | Dizziness or Faintness           | _____ |
| Are You Pregnant                | _____ |                                  |       |

Other Medical Conditions and Surgeries: \_\_\_\_\_

If you have been prescribed to physical therapy by a specialist or your primary doctor ; are you aware of your diagnosis? YES \_\_\_\_ NO \_\_\_\_

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Hertel and Brown Physical Therapy regardless of participation in or out-of-network. Should I default on my financial responsibility and collection is necessary, I will be responsible for collection costs that are incurred.

Patient/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I acknowledge that I have seen the "Notice of Privacy Practices". I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_