PREMIER PHYSICAL THERAPY, P.C.

Patient Information: All Patients Please Complete This Section	
Name:	Date of Injury:
Address:	Date of Birth: Age:
City/State/Zip:	Sex: ☐ Male ☐ Female
Home Phone:	Social Security No.:
Work Phone:	E-mail Address:
Cell Phone:	Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single

Insurance Information: Please Complete This Section if you have insurance	
Primary Insurance:	Secondary Insurance:
Address:	Address:
City/State/Zip:	City/State/Zip:
Phone:	Phone:
Claim/Group No.:	Claim/Group No.:
Policy No.:	Policy No.:
Relationship to insured: ☐ Spouse ☐ Self ☐ Child ☐ Other	Relationship to insured: ☐ Spouse ☐ Self ☐ Child ☐ Other

Employer Information: Please Complete This Section ONLY if your injury occurred while you were working	
Employer Name:	Claim/Group No.:
Insurance Co.:	Policy No.:
Address:	Phone No.:
City/State/Zip:	Contact Person:

Attorney Information: Please Complete This Section ONLY if you are represented by an attorney	
Attorney Name:	Phone No.:
Name of Firm:	Floor No. (if available):
Address:	Suite No. (if available):
City/State/Zip:	Contact Person:

Authorization To Release Information / Assignment of Benefits / Agreement and Consent to Treatment:	
√	I hereby authorize Premier Physical Therapy to release to my insurance company(s) and/or to my attorney named above any information acquired in the course of my examination or treatment.
√	I hereby agree to full responsibility for any expenses incurred by or on account of me (the patient), and hereby assign to Premier Physical Therapy any insurance and/or settlement benefits due to me (the patient) that are related to my financial obligation to this facility.
√	I understand my insurance coverage is a relationship between myself and my insurance company, and I agree to accept financial responsibility for payment of charges incurred. I hereby consent/agree to be treated.

YOUR Signature: ` ____ Date: ______________________________

(Patient or Guardian Must Sign if Patient is Under the age of 18)

MEDICAL HISTORY FORM

First Name: ______________________ Last Name: ______________________

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

PERSONAL HEALTH HISTORY (PAGE 1)

Major Medical Problems: Have you ever been hospitalized &/or operated on?	
Year	Medical Problems/Surgeries/Hospitalizations

CHIEF COMPLAINTS/ Location of Pain / Reason for Office Visit:

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength (if Known)	Frequency Taken
		☐ Daily ☐ As Needed
		☐ Daily ☐ As Needed
		☐ Daily ☐ As Needed
		☐ Daily ☐ As Needed
		☐ Daily ☐ As Needed
		☐ Daily ☐ As Needed
		☐ Daily ☐ As Needed
		☐ Daily ☐ As Needed

Allergies to medications

☐ None ☐ Penicillin ☐ Sulfa ☐ Iodine ☐ Codeine ☐ Aspirin ☐ Other:

SOCIAL HABITS

Alcohol	Do you drink alcohol? ☐ No ☐ Yes	If Yes, how often? ☐ Occasionally ☐ Socially ☐ Daily ☐ Heavily
Tobacco	Do you use tobacco? ☐ No ☐ Yes	If Yes, how often? ☐ Occasionally ☐ Socially ☐ Daily ☐ Heavily
Drugs	Do you currently use recreational or street drugs?	☐ Yes ☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes ☐ No

MEDICAL HISTORY FORM

First Name: ______________________ Last Name: ______________________

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

PERSONAL HEALTH HISTORY (PAGE 2)

Medical History: Please "X" the box if you have suffered any of the following		
☐ Asthma	☐ Diabetes	☐ Arthritis / Rheumatism / Gout
☐ Cancer	☐ Pacemaker	☐ Depression
☐ Heart Disease	☐ Stroke	☐ Thyroid Disease
☐ High Blood Pressure	☐ Bone Fracture	☐ Kidney Disease
☐ High Cholesterol	☐ Hepatitis	☐ Liver Disease
☐ GERD/Acid Reflux Disease	☐ Crohn's / Colitis	☐ Lung Disorder
☐ Seizure Disorder / Epilepsy	☐ HIV +	☐
☐ Anemia	☐ Osteoporosis	

FAMILY HISTORY	AGE	HEATH STATUS		LIST HEALTH PROBLEMS/CAUSE OF DEATH
Father		☐ Alive & Healthy ☐ Deceased	☐ Alive & with Health Problems ☐ Unknown	
Mother		☐ Alive & Healthy ☐ Deceased	☐ Alive & with Health Problems ☐ Unknown	
Brothers/ Sisters	☐ M ☐ F	☐ Alive & Healthy ☐ Deceased	☐ Alive & with Health Problems ☐ Unknown	
	☐ M ☐ F	☐ Alive & Healthy ☐ Deceased	☐ Alive & with Health Problems ☐ Unknown	

Briefly Explain How the Accident Happened (if applicable):

PRIOR INJURIES: It is VERY important to list all prior or current injuries related or unrelated to this incident. Why? It will help us better understand and document your current problem

Date or Year of Injury	Type of Injury (i.e.-fall, auto, work, etc.)	How Long Did You Get Treatment?	List Body Area(s) Injured	Did you make a Full Recovery?
				☐ No ☐ Yes ☐ Almost
				☐ No ☐ Yes ☐ Almost
				☐ No ☐ Yes ☐ Almost
				☐ No ☐ Yes ☐ Almost

OCCUPATION (List): ______________________

Are you currently: ☐ Retired ☐ Full time Student ☐ Part time student ☐ Disabled ☐ Working Full Time (no restrictions) ☐ Between jobs

☐ Working part time (no restrictions) ☐ Working Part time (with restrictions) ☐ Working Full Time (with restrictions)

Please List Any Other Doctors you saw related to this injury & any diagnostic studies (x-ray, MRI, etc)

PATIENT SIGNATURE: ______________________ DATE: ______________________