ALIQUIPPA
2284 Brodhead Rd
Aliquippa, PA 15001
(724) 788-1770

MONACA
3468 Brodhead Rd#10
Monaca, PA 15061
{878) 201-3945

NEW BRIGHTON
2236 3rd Ave
New Brighton, PA 15066
(724) 846-1633

PATIENT INFORMATION

First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	____ Male ____ Female	S.S. #: - -
Home Phone: ( ) -	Cell Phone: ( ) -	Email:	
Spouse:	Please check below how you heard about Jamie's Physical Therapy:		

____Dr. _____ ____Ins. Plan ____ Family ____Friend ____Former Patient ____Yellow Pages
Close to work/home Website Facebook Street Sign Other:

WORK INFORMATION

Employer:	Work Phone: ( ) -	Ext:
Occupation:	Employment Status ___Full Time ___Part Time ___Retired ___Not Employed	

CARE PROVIDER INFORMATION

Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr./PCP:	Regular Dr./PCP Phone: ( ) -

INSURANCE INFORMATION

Primary Insurance Name:

Subscriber's Name (If different):	Birth Date: / /
I.D. #:	Group/Policy #:

Patient's Relationship to Subscriber: ___Self ___Spouse ___Child Other:

Name of Secondary Insurance:

Primary Insurance Name:

Subscriber's Name (If different):	Birth Date: / /
I.D. #:	Group/Policy #:

Patient's Relationship to Subscriber: ___Self ___Spouse ___Child ___Other:

IN CASE OF EMERGENCY

Name of Local Friend or Relative (Not Living at Same Address):

Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

I authorize my insurance benefits be paid directly to Jamie's Physical Therapy & Sports Medicine. I understand that I am financially responsible for any balance. I also authorize Jamie's Physical Therapy & Sports Medicine to release any information required to process my claims.

PATIENT/GUARDIAN SIGNATURE DATE

AUTO OR WORK INJURY CLAIM

Insurance Name:		____Auto ____Workers' Comp	
Adjuster/Claim Manager:		Phone: ( ) - Ext:	
Claims Address:	City:	State:	Zip:
Claim #:	Date of Injury: / /	Cause:	

ATTORNERY INFORMATION

Name:	Law Firm:	Phone: ( ) -	
Address:	City:	State:	Zip:

We would like to make you aware that auto insurance companies cover Physical Therapy benefits as long as there is Personal Injury Protection (PIP) available on the claim. We do call on every claim to verify PIP is available and that an open and active claim exists for the auto accident; however, adjustors are unable to reveal the total dollar amount remaining for use. Therefore, as the patient, it is your responsibility to know and to understand what benefits are covered by your auto insurance. We will continue to bill your auto insurance until PIP has been exhausted and claims are denied. As backup to bill these potentially denied claims, it is our policy to obtain private medical insurance information in addition to your auto insurance. If you do not have private medical insurance and/or if you do not wish to provide your private medical insurance information, all denied and unpaid balances will be your responsibility. Please let us know if you have any questions about this policy or the information conveyed.

PATIENT/GUARDIAN SIGNATURE DATE

PAST MEDICAL HISTORY FORM

	YES	NO
Cancer	_____	_____
• Specify: _____		
Heart Condition	_____	_____
• Specify: _____		
High Blood Pressure	_____	_____
Low Blood Pressure	_____	_____
Pacemaker	_____	_____
Diabetes Type 1	_____	_____
Diabetes Type 2	_____	_____
Neuropathy	_____	_____
Reduced Sensation	_____	_____
Asthma	_____	_____
Emphysema	_____	_____
Osteoarthritis	_____	_____
Rheumatoid Arthritis	_____	_____
Gout	_____	_____
Fracture	_____	_____
Hernia	_____	_____
Osteoporosis	_____	_____

	YES	NO
Stroke	_____	_____
Alzheimer's	_____	_____
Parkinson's	_____	_____
Multiple Sclerosis	_____	_____
Epilepsy	_____	_____
Muscular Dystrophy	_____	_____
Traumatic Brain Injury	_____	_____
Polio	_____	_____
Fibromyalgia	_____	_____
Lupus	_____	_____
Anxiety	_____	_____
Depression	_____	_____
Allergies	_____	_____
Anemia	_____	_____
Blood Clots	_____	_____
Hearing Loss	_____	_____
Poor Eyesight	_____	_____

Other: _____

_____

_____

Height: _____ Weight: _____

EXERCISE : None 1-2 xWeek 3-4 xWeek S+xWeek

What types of exercise do you perform?: _____

WORK ACTIVITY: _____ Sitting _____ Standing _____ Light Labor _____ Heavy Labor

HABITS: ____ Smoking (_____Packs a Day) _____ Alcohol (_____Drinks aWeek) _____ Coffee/Soda (_____Cups aWeek)

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy? _____ YES _____ NO If yes list name: _____

List all medications you are currently taking: _____

_____

_____

List all previous surgeries: _____

_____

Are you pregnant? ___ YES ___ NO

Have you had Physical Therapy before? ___ YES ___NO Where: _____

Have you had any injuries related to work? _____ YES _____ NO

If yes list body part and date: _____

Have you had any injuries related to Auto Accidents? _____ YES ___ NO

If yes list body part and date: _____

_____ _____

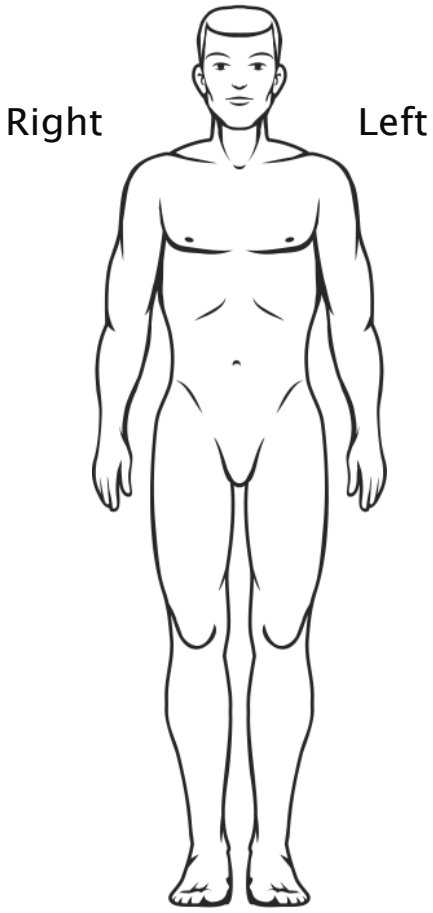
PATIENT/GUARDIAN SIGNATURE DATE

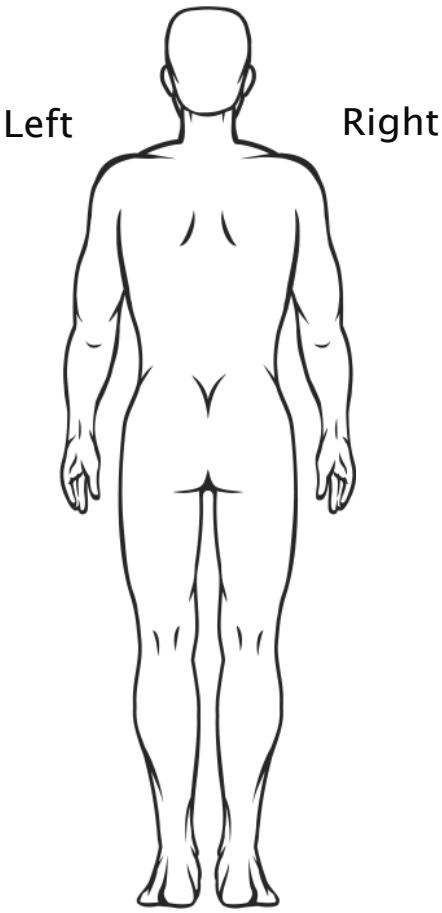
PAIN AND SYMPTOM STATUS REPORT

Using the symbols below, please draw at the location on the body outlines the type of pain you are experiencing.

Dull/Achy: MMM Numbness/ Burning: --- ---- ---- Sharp: / / / /

Tingling: 0 0 0 0 Shooting: ▭▭▭ Other: XXXX Describe:_____





My Chief Complaint is:_____ Date First Symptom of your problem occurred on: _____

Please rate your pain by circling the one number that best describes your pain at its **WORST.**

0 1 2 3 4 5 6 7 8 9 10

No pain Pain as bad as you can imagine

Please rate your pain by circling the one number that best describes your **CURRENT** level of pain.

0 1 2 3 4 5 6 7 8 9 10

No pain Pain as bad as you can imagine

Please rate your pain by circling the one number that best describes your pain at its **BEST.**

0 1 2 3 4 5 6 7 8 9 10

No pain Pain as bad as you can imagine

_____

PATIENT/GUARDIAN SIGNATURE DATE