



ALIQUIPPA  
284 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:	<input type="checkbox"/> Male <input type="checkbox"/> Female	S.S. #: - -
Home Phone: ( ) -	Cell Phone: ( ) -	Email:	
Spouse:	Please check below how you heard about Jamie's Physical Therapy:		
<input type="checkbox"/> Dr. _____	<input type="checkbox"/> Ins. Plan	<input type="checkbox"/> Family	<input type="checkbox"/> Friend
<input type="checkbox"/> Former Patient	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Close to work/home	<input type="checkbox"/> Website
<input type="checkbox"/> Facebook	<input type="checkbox"/> Street Sign	<input type="checkbox"/> Other:	

## WORK INFORMATION

Employer:	Work Phone: ( ) -	Ext:
Occupation:	Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:	
Name of Secondary Insurance:	
Primary Insurance Name:	
Subscriber's Name (If different):	Birth date: / /
I.D. #:	Group/Policy #:
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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.

## AUTO OR WORK INJURY CLAIM

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

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

**ATTORNEY 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 x Week \_\_\_ 3-4 x Week \_\_\_ 5+ x Week

What types of exercise do you perform?: \_\_\_\_\_

WORK ACTIVITY: \_\_\_ Sitting \_\_\_ Standing \_\_\_ Light Labor \_\_\_ Heavy Labor

HABITS: \_\_\_ Smoking (\_\_\_ Packs a Day) \_\_\_ Alcohol (\_\_\_ Drinks a Week) \_\_\_ Coffee/Soda (\_\_\_ Cups a Week)

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: \_\_\_\_\_

**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.

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

Dull/Achy: MMM

Numbness/Tingling: O O O O

Burning: --- ---- -----

Shooting:

Sharp: ///

Other: X X X X Describe: \_\_\_\_\_

Right

Left



Left

Right



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