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

BLOOD PRESSURE	**YES**	**NO**
Hypertension	____	____
Low Blood Pressure	____	____
Normal Blood Pressure	____	____

HEART DISEASE	**YES**	**NO**
Heart Attack	____	____
Atherosclerotic Disease	____	____
Rheumatic Heart Disease	____	____
Heart Murmur	____	____
Do you have a pacemaker	____	____

MUSCLE CONDITION	**YES**	**NO**
Carpal Tunnel R/L	____	____
Tennis Elbow R/L	____	____
Back/Neck Problems	____	____
Limited Limb Movement	____	____

LUNGS:	**YES**	**NO**
Asthma	____	____
Emphysema	____	____
Shortness of Breath	____	____

JOINT CONDITIONS	**YES**	**NO**
Upper Extremity	____	____
Lower Extremity Dislocation	____	____

OTHER CONDITIONS	**YES**	**NO**
Muscular Dystrophy	____	____
Rheumatoid Arthritis	____	____
Multiple Sclerosis	____	____
Epilepsy	____	____
Gout	____	____
Fibromyalgia	____	____
Diabetes	____	____
Hearing Loss	____	____
Poor Eyesight	____	____
Fainting	____	____
Polio	____	____
Cancer	____	____

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

STRESS LEVEL: ___ Low ___ Medium ___High

What things cause stress in your life?: _____

HABITS: ___Smoking (____Packs a Day) ___Alcohol (____Drinks a Week) ___Coffee/Soda (____Cups a Week)

Are you taking any seizure medication? ___ YES ___NO If yes list name: _____

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 surgeries in the past two years (Including dates):

_____

Are you pregnant? ___ YES ___ NO

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

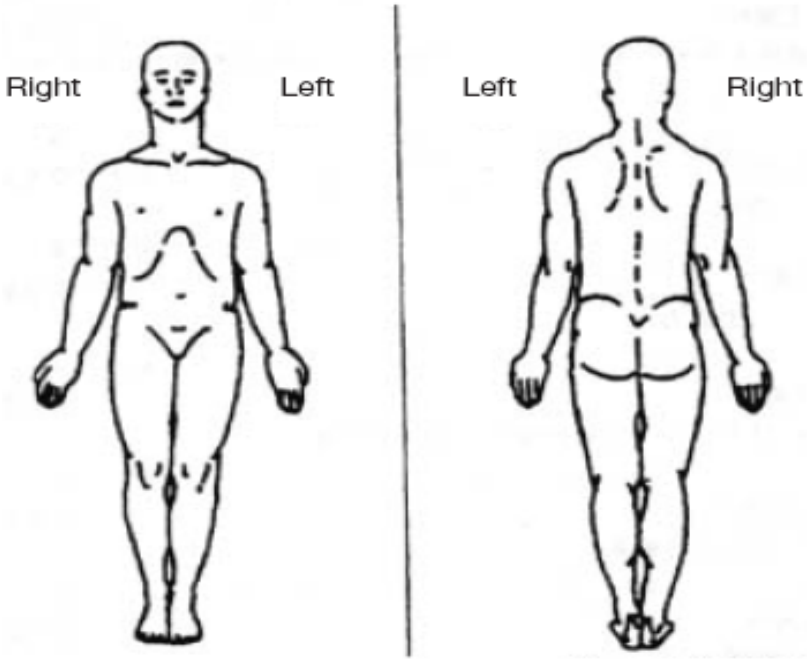
_____

PATIENT/GUARDIAN SIGNATURE DATE

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.

Ache: MMM Burning: --- ---- ---- Stabbing: / / / /
Numbness: O O O O Pins and Needles: ▭▭▭ Other: X X X X



My Chief Complaint is: _____
Date First Symptom of your problem occurred on: _____
2nd Complaint _____
3rd Complaint _____

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

_____
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