PHYSICAL THERAPY & WELLNESS

First Name ______________________ Middle _______ Last ______________________

Circle One: Male/Female DOB ______________ Email ______________________

ADDRESS __________________ CITY ________________ ST ______ ZIP CODE ______________

Cell Phone __________________ Home Phone ______________________

Emergency Contact ______________________ Relationship ____________ Phone ______________

Referring Doctor's Name ______________________ Phone ______________________

Last Seen by referring doctor _____/_____/_____ Next Dr Appt ______________________

Date of Injury____________________ Date of Surgery (if applicable) ______________________

ARE YOU RECEIVING HEALTH CARE SERVICES OF ANY KIND IN YOUR HOME? ___ YES ___ NO

IS THERE AN ATTORNEY INVOLVED IN YOUR CASE/INJURY? ___ YES ___ NO

INSURANCE INFORMATION

PRIMARY ______________________

Name of Policy Holder ______________________ Policy Holder DOB __________

SECONDARY ______________________

Name of Policy Holder ______________________ Policy Holder DOB __________

CONSENT FORM/ASSIGNMENT OF BENEFITS/PRIVACY PRACTICES

INITIAL the following:

_______ I hereby agree and give my consent for Day One Physical Therapy & Wellness to provide physical therapy treatment. I authorize Day One Physical Therapy & Wellness to release and obtain all information necessary from my referring physician, other physician, insurance carriers, or third party payers. I hereby assign Day One all payments for services rendered to myself or my dependents and understand that I may be responsible for any uncovered charges.

______ I have been notified of this office's ***Notice of Privacy Practices (HIPPA)***

Please give name(s) of relative, friend or other representative who may have access to your medical records:

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

Signature (Patient/Guardian): ______________________ Date: ______________

DAY ONE

PHYSICAL THERAPY & WELLNESS

MEDICAL HISTORY

Have you ever had OR currently have any of the following conditions?

High Blood Pressure	Yes	No	Kidney/Liver Problems	Yes	No
Cardiac Conditions (Heart Attack or Pacemaker)	Yes	No	Vision Problems (Glaucoma or Cataracts)	Yes	No
Circulation Problems	Yes	No	Claustrophobia	Yes	No
Seizures	Yes	No	Dizzy Spells	Yes	No
Cholesterol	Yes	No	Diabetes	Yes	No
Allergies	Yes	No	Nervous Disorders	Yes	No
Fractures	Yes	No	Cancer	Yes	No
Arthritis/Osteoporosis	Yes	No	Metal Implants	Yes	No
Speech Problems	Yes	No	Sensitivity to heat/cold	Yes	No
Stroke	Yes	No	Pregnant	Yes	No

Surgeries ____

____

Current Medications ____

____

What are we seeing you for today? (circle all that apply)

Shoulder:	Right	Left	Bilateral	**Knee**:	Right	Left	Bilateral
Ankle/Foot:	Right	Left	Bilateral	**Hip**:	Right	Left	Bilateral
Neck:	Right	Left	Bilateral	**Back**:	Right	Left	Bilateral
Face/Head:	Right	Left	Bilateral	**Arm/Hand**:	Right	Left	Bilateral

Briefly describe the history/symptoms of your present illness or injury ______________________

____

Where did your injury occur? Home Work School Motor Vehicle Accident

Other ____

Have you ever had physical therapy for your current condition? Yes No

REVISED 7/15

Day One Physical Therapy & Wellness
CONSENT FORM/ASSIGNEMENT OF BENEFITS/PRIVACY PRACTIES

Please initial the following:
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Signature of patient: ____ Date: _________

(Parent or Guardian, if applicable) _________________________________ Date: _________

- Are you receiving any kind of health services in your home? _____YES _____NO
- Is there any attorney involved in your case history? _________ YES ________NO