Midwest Physical Therapy, LLC

Name: _____ Birthdate: _____

Gender: M / F

Smoker: Yes / No

Pregnant: Yes / No

How would you rate your general health? Excellent Good Fair Poor

Do you exercise regularly? Y / N Activity types_____

Current medications (prescription, over-the-counter):_____

_____

Past Medical History: Have you ever been told you have any of the following?

Cancer	Yes	No	Ulcers	Yes	No
Heart problems	Yes	No	Infectious diseases	Yes	No
High Blood Pressure	Yes	No	Lung problems	Yes	No
Angina/Chest Pain	Yes	No	Hepatitis	Yes	No
Asthma	Yes	No	Anemia	Yes	No
Diabetes	Yes	No	Allergies	Yes	No
Osteoporosis	Yes	No	Fibromyalgia	Yes	No
Thyroid problems	Yes	No	Kidney disease	Yes	No
Rheumatoid arthritis	Yes	No	Stroke	Yes	No
Osteoarthritis	Yes	No	Seizures/Epilepsy	Yes	No
Depression	Yes	No	Other _____		

Currently, are you experiencing any of the following? (circle all that apply):

Fever/chills/sweats Poor balance (falls) Unexplained weight loss Numbness/tingling Changes in appetite

Difficulty swallowing Pelvic pain Depression Shortness of breath Dizziness

Changes in bowel or bladder function Nausea/vomiting Night pain Headaches

Current History:

What date (approximately) did your present symptoms start? _____How? Gradually / Suddenly / Injury

What may have caused your symptoms? _____

How have your symptoms changed?: getting better about the same getting worse

What makes your symptoms better? _____

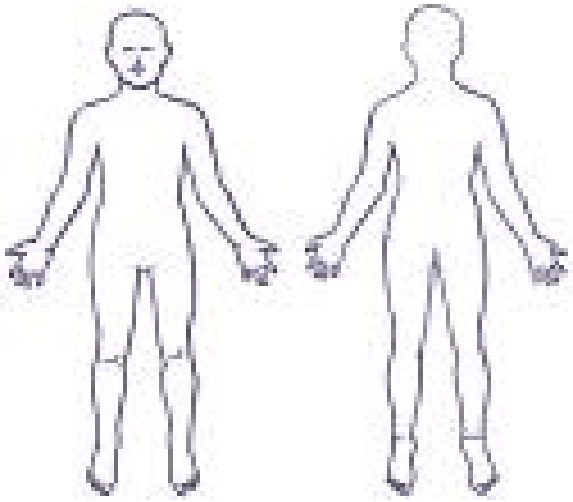
What makes your symptoms worse? _____

Have you seen any other (doctor, chiropractor, PT, surgeon) for your symptoms? MRI? Y / N

Name of primary doctor or clinic:

_____

Indicate where you feel your symptoms:



Rate the level of pain or discomfort you feel today

1 10

No pain severe pain

Is this (better) or (worse) than most days?

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Name: _____ Birthdate: _____
First MI Last Month/Day/Year

Address: _____
Street City State Zip code

Cell phone: _____ Ok to text or leave message? Y / N Secondary phone: _____

Email: _____ Do you want appointment reminder? Y / N Text / Voice / Email

Insurance Information (please present card and picture ID)

Primary health insurance: _____ ID number _____

Policy holder, if other than patient _____
Name Birthdate

Secondary health insurance: _____ ID number _____

Policy holder, if other than patient _____
Name Birthdate

If your injury is related to an AUTO ACCIDENT or WORK INJURY, please provide the following information:

Auto insurance _____ Claim # _____ Date of accident _____

Work comp ins _____ Claim # _____ Date of injury _____

Social Security Number _____ Name of employer _____

Attorney name, if applicable _____ Phone _____

Authorization and Acknowledgement of Policies – Please read and initial each statement, then sign below to accept.

_____ Consent for Care: I hereby consent to care rendered by practitioners at this clinic. I reserve the right to refuse treatment at any time during the course of care.

_____ Privacy Notice: I understand that my personal health information may be disclosed as mandated by HIPAA. I am aware that I may request a copy of this clinic's Privacy Notice at any time.

_____ Assignment of Benefits: I authorize my insurance(s) to issue payment directly to this clinic. I understand that I am liable for any amounts determined to be patient responsibility by my insurance(s).

_____ Financial Responsibility: I understand that I am responsible for full payment of services as determined by my insurance. Knowledge of coverage is the responsibility of the patient. If your insurance company requires a referral from another doctor, you are responsible for obtaining it. We are happy to assist you in determining your insurance coverage; however, eligibility quotes are not a guarantee of payment.

If you elect not to use insurance, a discount may be available if payment is made at time of service. We promise to work with you to make physical therapy an affordable health care option.

Patient statements are sent every 60 days and balance owed is due within 30 days of receipt. Statements may be sent via email if one has been provided. Returned checks will be assessed a $12 fee.

Patient Signature: _____ Date: _____

If patient is a minor child, parent/legal guardian signature _____

We reserve the right to make changes to our office policies. Any policy changes will be posted.