

Date _____

Patient Information Form

Page 1

Patient # _____

Name _____ Date of Birth _____ Age _____ SS# _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Sex _____ Marital Status _____

Occupation _____ Business Name _____

Business Address _____ Business Phone _____

Date of Accident _____ Type of Accident _____

Injury Area _____ Post-OP _____

Primary Insurance _____ Insurance ID# _____

Spouse Name _____ D.O.B. _____

Insurance Address _____ Insurance Phone _____

Policy/Group # _____ Adjuster _____ Claim # _____

Secondary Insurance _____ Insurance ID# _____

Insurance Address _____

Insurance Phone _____ Policy/Group # _____

Physician's name _____ Primary Doctor _____ Primary's phone _____

Physician's Address _____

Do you have a **Rehab Nurse or Case Worker**? _____ Their Name _____

Address _____ Phone Number _____

Emergency Contact Name _____ Phone Number _____

How Did You Hear About Us? Friend Hospital TV Doctor PT Center Newspaper Other _____

Have you received any outpatient physical or speech therapy in this calendar year? _____ **If yes, when?** _____ **where?** _____

Have you received any outpatient occupational therapy in this calendar year? _____ **If yes, when?** _____ **where?** _____

Wheelchair Incontinence Products

MEDICAL/SOCIAL HISTORY

With whom do you live?

- Alone Spouse only
- Spouse and child(ren)
- Child(ren) only Other relatives
- Other _____

Where do you live?

- Private home Apartment
- Assisted living/ group home
- Other _____

Does your home have:

- Stairs, no railing Stairs, railing
- Ramps Elevator
- Assistive devices _____
- Obstacles _____

Do you use:

- Cane Glasses
- Walker Hearing aids

Is there any chance that you are currently pregnant?

- Yes No

Within the past year, have you had any of the following symptoms:

- Chest pain
- Heart palpitations
- Shortness of Breath
- Dizziness or blackouts
- Coordination problems
- Weakness in arms or legs
- Loss of balance
- Difficulty walking
- Joint pain or swelling
- Pain at night
- Difficulty sleeping
- Loss of appetite
- Nausea/ vomiting
- Weight loss/ gain
- Incontinence
- Bladder, bowel or bathroom issues

Other _____

Please check if you have ever had:

- Arthritis
- Broken bones, fractures
- Osteoporosis
- Blood disorders
- Circulation/vascular disorder
- Heart problems
- Pacemaker
- High blood pressure
- Lung problems
- Stroke
- Diabetes/high blood sugar
- Low blood sugar/hypoglycemia
- Head injury
- Multiple sclerosis
- Muscular dystrophy
- Parkinson's disease
- Seizures/ epilepsy
- Developmental/growth disorders
- Thyroid problems
- Cancer
- Infectious disease
- Kidney problems
- Ulcers/ stomach problems
- Skin diseases
- Depression
- Other _____

Have you ever had surgery?

- Yes No

Surgery _____ Date _____

Do you take prescription medications?

- Yes No

If yes, please list _____

Do you take any non-prescription medication? Yes No

- Advil/Aleve
- Ibuprofen/ Naproxen
- Aspirin
- Tylenol
- Other _____

Within the past year, have you had any of the following tests?

- Arthroscopy
- Biopsy
- Blood tests
- Bone scan
- CT scan
- Doppler ultrasound
- Echocardiogram
- EMG
- EKG
- MRI
- Myelogram
- Nerve conduction velocity
- Pulmonary function test
- Stress test
- X-rays
- Other: _____

I certify that all of the information on this intake form is true and correct to the best of my knowledge and that I understand the policies of Aquahab Physical Therapy (Center). I give my consent to receive any and all treatment that is rendered at Aquahab Physical Therapy. I am responsible for notifying the Center of any changes in my health or billing information. I give consent for the Center to bill my insurance company and for assignment of direct payment to the Center by my insurance company. The Center will make every effort to collect payment from my insurance company, however I understand that regardless of my account status, I am ultimately responsible for all charges incurred for professional services rendered at Aquahab Physical Therapy to the extent that the law allows.

Signature _____ Date _____

I authorize the release of any all information in your possession, custody, and control, including x-rays, medical records, and emergency room records and test reports. The undersigned expressly authorizes the release of my complete hospital/physician's office chart to Aquahab Physical Therapy. I also give consent for the Center to release their records, within the guidelines of the law, as necessary to my physician, insurance company, rehab nurse/case manager or attorney.

Signature _____ Date _____