Allied Physical Therapy

Patient Information Form

Patient Information

Last Name _____ First Name _____ MI _____ SSN _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Gender _____ Marital Status _____ Email _____

Emergency Contact

Last Name _____ Relationship _____

First Name _____ Phone _____

Employer

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

Problem

Problem Description _____ Date of Injury _____

Referred By _____ Primary Care Physician _____

Latest Referral Information _____ Motor Vehicle Accident _____

That occurred in: _____

Notes: _____

Primary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Secondary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Tertiary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

I authorize release of information requested by my insurance plan for payment.
I understand that I am responsible for any balance due.
I agree to comply with the terms as outlined on the Patient Registration form.

Any Cancellation or No Show wiithout 24 hour notice, will result in a $50 Charge

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

(You have the right to refuse to sign this acknowledgement if you so choose.)

Signature: _____ Date: _____

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Medical History Form

Name: _____

Primary Care Physician: _____

Referring Physician: _____

Have you been experiencing any of the following (check all that apply)?

❑ nausea/vomiting
❑ dizziness/lightheaded
❑ shortness of breath
❑ weight loss/gain
❑ heartburn/indigestion
❑ fainting
❑ difficulty maintaining Balance
❑ difficulty swallowing
❑ cough
❑ headaches
❑ changes in bowel/bladder function

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

❑ cancer
❑ depression
❑ thyroid problems
❑ heart problems
❑ lung problems
❑ diabetes
❑ chest pain/angina
❑ tuberculosis
❑ osteoporosis
❑ high blood pressure
❑ rheumatoid arthritis
❑ pneumonia
❑ constipation
❑ hepatitis
❑ liver problems
❑ fatigue
❑ numbness or tingling
❑ eye
❑ fever/chills/sweats
❑ muscle weakness
❑ circulation problems
❑ asthma
❑ multiple sclerosis
❑ epilepsy
❑ diarrhea
❑ stroke
❑ ulcers
❑ blood clots
❑ other arthritic conditions
❑ anxiety
❑ bladder/urinary tract infection
❑ pelvic inflammatory disease
❑ surgeries_____
❑ anemia
❑ kidney problem/infection
❑ bone or joint infection
❑ sexually transmitted disease/HIV
❑ chemical dependency (alcoholism)

Please answer the following questions:

Hand Dominance: ❑ Left ❑ Right

Are you on a work restriction from your doctor? ❑ Yes ❑ No

Are you latex sensitive? ❑ Yes ❑ No

Do you use tobacco? ❑ Yes ❑ No

Do you have a pacemaker? ❑ Yes ❑ No

Are you currently pregnant or think you might be pregnant? ❑ Yes ❑ No

Are you presently undergoing or have undergone psychological counseling? ❑ Yes ❑ No

Have you received any physical therapy/chiropractic care this year? ❑ Yes ❑ No

Have you had two or more falls in the last year? ❑ Yes ❑ No

My symptoms are currently: ❑ Getting Better ❑ Getting Worse ❑ Staying about the same

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ❑ Yes ❑ No

Are you currently receiving Home Health Care from a Nurse or Physical Therapist? ❑ Yes ❑ No

How does your current condition limit your ability to perform what you love to do?

_____

_____

_____

Please tell us how you found us:

- ❑ My Doctor Referred me to Allied Physical Therapy
- ❑ A Friend/Family Member Referred me to Allied Physical Therapy
- ❑ Other _____

Medication List

Please list all Medications, including all prescriptions, over-the-counter medications, herbals, vitamins, minerals, and dietary supplements. Include the dosage, frequency, and administrative method for each medication.

Medication	Dosage	Frequency	Method of Administration
		❏ As Needed ❏ Once Daily ❏ Twice Daily ❏ Three Times Daily ❏ Other:	❏ Oral ❏ Sublingual ❏ Topical ❏ Subcutaneous Injection ❏ Other:
		❏ As Needed ❏ Once Daily ❏ Twice Daily ❏ Three Times Daily ❏ Other:	❏ Oral ❏ Sublingual ❏ Topical ❏ Subcutaneous Injection ❏ Other:
		❏ As Needed ❏ Once Daily ❏ Twice Daily ❏ Three Times Daily ❏ Other:	❏ Oral ❏ Sublingual ❏ Topical ❏ Subcutaneous Injection ❏ Other:

ALLERGIES: Please list any medication(s) you are allergic to:

____

____

____

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Consent for Treatment

I do hereby consent to such treatment by the authorized licensed personnel of Allied Physical Therapy as may be dictated by prudent medical practice by my illness, injury or condition.

Thank you for allowing us the opportunity to serve you. If you have any questions about the above information or any uncertainty regarding your insurance coverage, please ask for assistance.

ACKNOWLEDGEMENT OF PATIENT INFORMATION PRACTICES

I have read and fully understand Allied Physical Therapy's Notice of Patient Information Practices. I understand that Allied Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Allied Physical Therapy's Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing.

Appointment Reminder Consent

Complete and sign below to give your permission for Allied Physical Therapy to provide automatic appointment reminder service by email or by cell phone text message.

❑ Email: _____

❑ Telephone Reminder: _____

❑ Text: _____

Phone Carrier

❑ AT&T ❑ Boost Mobile ❑ Cingular ❑ Cricket Wireless ❑ MetroPCS

❑ Sprint PCS ❑ T-Mobile ❑ US Cellular ❑ Verizon ❑ Virgin Mobile

_____ _____

Signature Date

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1413 Viscaya Pkwy, Cape Coral, FL 33990 • (239) 242-0070

COVID-19 PATIENT PRE-SCREENING QUESTIONNAIRE

We appreciate your cooperation and patience in helping to keep our patients and staff safe and healthy.

Have you traveled outside the U.S. in the past 30 days? ❑ YES ❑ NO

If YES, where? _____

Have you been in personal contact with a person infected with Coronavirus or who has traveled to an area with widespread and ongoing transmission of Coronavirus in the past 30 days? ❑ YES ❑ NO

IN THE LAST 48 HOURS:

Have you had a fever (99.5°+)? ❑ YES ❑ NO

Have you experienced any:

Coughing? ❑ YES ❑ NO
Sore Throat? ❑ YES ❑ NO
Difficulty Breathing? ❑ YES ❑ NO
Muscle Aches? ❑ YES ❑ NO
Stomach Pain? ❑ YES ❑ NO

Print Name: _____

Signature: _____ Date: _____

**Please return this form to the front desk when it is completed.

*** Note: If you plan to visit for consecutive days, please immediately advise us if any of your responses change. The information collected on this form will be used to determine your access to the Allied Physical Therapy Clinic.

OFFICE USE ONLY

Access to Clinic is ❑ APPROVED ❑ DENIED

signed _____ date:_____