

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 _____	Subscriber Name _____
ID _____	Max Benefit _____	Relationship _____
Group # _____	CoPay _____	Date of Birth _____
ColInsurance _____		

Secondary Insurance

Insurance _____	Deductible _____	Subscriber Name _____
ID _____	Max Benefit _____	Relationship _____
Group # _____	CoPay _____	Date of Birth _____
ColInsurance _____		

Tertiary Insurance

Insurance _____	Deductible _____	Subscriber Name _____
ID _____	Max Benefit _____	Relationship _____
Group # _____	CoPay _____	Date of Birth _____
ColInsurance _____		

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 without 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: _____

Medical History Form

Name: _____

Primary Care Physician: _____

Referring Physician: _____

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

- | | | |
|---|--|--|
| <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> dizziness/lightheaded | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> weight loss/gain | <input type="checkbox"/> heartburn/indigestion | <input type="checkbox"/> fainting |
| <input type="checkbox"/> difficulty maintaining Balance | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> cough |
| <input type="checkbox"/> headaches | <input type="checkbox"/> changes in bowel/bladder function | |

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

- | | | |
|---|---|---|
| <input type="checkbox"/> cancer | <input type="checkbox"/> depression | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> lung problems | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> chest pain/angina | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> pneumonia |
| <input type="checkbox"/> constipation | <input type="checkbox"/> hepatitis | <input type="checkbox"/> liver problems |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> numbness or tingling | <input type="checkbox"/> eye |
| <input type="checkbox"/> fever/chills/sweats | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> circulation problems |
| <input type="checkbox"/> asthma | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> diarrhea | <input type="checkbox"/> stroke | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> other arthritic conditions | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> bladder/urinary tract infection | <input type="checkbox"/> pelvic inflammatory disease | |
| <input type="checkbox"/> surgeries _____ | | |
| <input type="checkbox"/> anemia | <input type="checkbox"/> kidney problem/infection | |
| <input type="checkbox"/> bone or joint infection | <input type="checkbox"/> sexually transmitted disease/HIV | |
| <input type="checkbox"/> 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
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> Three Times Daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous Injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> Three Times Daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous Injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> Three Times Daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous Injection <input type="checkbox"/> Other:

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

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



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: _____