Appt Date: _____ Medical History
Appt Time: _____

NAME: _____ DATE OF BIRTH _____/_____/_____ S.S.# _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail: _____ Marital Status: S ___ M ___ D ___ W ___ Sex: M ___ F ___

How would you like us to remind you of your appts?_____

Referring Dr. _____ Primary Care Dr: _____

Diagnosis/Primary complaint: _____ Date of next referring Dr's appt: _____

Work related (___) Auto related (___) Other (___) Date of Injury / onset: _____

Employer's name: _____ Employer's Tel # _____

Claim # _____ Auth. # _____ Adjuster: _____

Insurance Co _____ Insured's Name: _____

ID: _____ Group # _____ **Height:**_____

Insurance Benefits: Deductible _____ Co-Pay _____ Notes: _____ **Weight:**_____

How were you referred to TPT: INS __ Dr __ Friend(name) ___ Previous pt ___ Other ____

Have you received any physical therapy or chiropractic services this year? Y ____ N _____

Are you currently receiving any home health services? Y___ N ____

Have you had any Diagnostic or Rehabilitative Services for this injury? MRI ___ Xray___ Other ___ Surgery ____

Current Symptoms: Pain__ Numbness___ Stiffness___ Weakness___ Condition: New __ Acute__ Chronic ___

| Do you have any of the following - | Yes | No | Do you have any of the following - | Yes | No |
|---|---|---|---|---|---|
| Cholesterol (high ?) | _____ | _____ | Infectious Disease | _____ | _____ |
| Allergies | _____ | _____ | Diabetes | _____ | _____ |
| Coronary/Cardiac Heart Disease | _____ | _____ | Cancer or Chemo/ Radiation | _____ | _____ |
| Do you have a PACEMAKER | _____ | _____ | Arthritis/ Swollen Joints | _____ | _____ |
| Asthma, Bronchitis or Emphysema | _____ | _____ | Osteoporosis | _____ | _____ |
| Shortness of Breath/Chest Pain | _____ | _____ | Varicose Veins | _____ | _____ |
| High Blood Pressure | _____ | _____ | Gout | _____ | _____ |
| Heart Attack/ Surgery | _____ | _____ | Sleeping Difficulties | _____ | _____ |
| Stroke/ TIA | _____ | _____ | Emotional/ Psychological Problems | _____ | _____ |
| Blood Clot/Emboli | _____ | _____ | Bowel or Bladder Problems | _____ | _____ |
| Epilepsy/ Seizures | _____ | _____ | Severe/ Frequent Headaches | _____ | _____ |
| Thyroid Trouble/ Goiter | _____ | _____ | Vision/ Hearing Difficulties | _____ | _____ |
| Anemia | _____ | _____ | Dizziness or Faintness | _____ | _____ |
| Are you pregnant? | Y _____ | N_____ | Alcohol Consumption No____ | Amount Daily____ | Wkly__ |

Smoke No ___ Amount Daily ____ Wkly ____

List Medications & dosage you are taking: _____

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment to Trittschuh Physical Therapy Inc regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for all collection costs that are incurred. I acknowledge that I have seen and understand the "Notice of Privacy Practices'

Patient/ Parent/ Guardian Signature: _____ Date: _____