

PATIENT INFORMATION:		
TODAY'S DATE:	HOW DID YOU HEAR ABOUT US?:	
LAST NAME:	FIRST NAME:	
STREET ADDRESS:		
CITY:	STATE:	ZIP:
EMAIL ADDRESS:		
MARTIAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED		
BIRTHDATE:	AGE:	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
EMPLOYER/SCHOOL:		
EMPLOYER/SCHOOL ADDRESS:		
PATIENT CONTACT PHONE NUMBERS:		
HOME #:	CELL #:	WORK #:
SPOUSE/PARENT NAME:		PHONE #:
EMERGENCY CONTACT:		PHONE #:
BEST TIME AND NUMBER TO REACH YOU:		
PHYSICIAN INFORMATION:		
PRIMARY CARE PHYSICIAN NAME:		
ADDRESS:		
PHONE #:	FAX #:	
SPECIALTY PHYSICIAN NAME:	SPECIALTY: <input type="checkbox"/> ORTHO <input type="checkbox"/> NEURO <input type="checkbox"/> OTHER _____	
ADDRESS:		
PHONE #:	FAX#:	
HEALTH INSURANCE INFORMATION:		
PRIMARY INSURANCE COMPANY:		SECONDARY INSURANCE COMPANY:
ID #:	GROUP #:	AUTH #:
INSURED'S NAME:		INSURED'S SOCIAL SECURITY #:
DEDUCTIBLE: <input type="checkbox"/> YES <input type="checkbox"/> NO AMOUNT:		PHYSICAL THERAPY CO-PAY: <input type="checkbox"/> YES <input type="checkbox"/> NO AMOUNT:
WORKER'S COMPENSATION/MOTOR VEHICLE ACCIDENT INFORMATION:		
INSURANCE COMPANY:		CLAIM #:
ADDRESS:		
ADJUSTOR'S NAME:		PHONE #:
INJURY DATE:	OUT OF WORK: <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, SINCE:
ATTORNEY INFORMATION:		
ATTORNEY NAME:		
ADDRESS:		
PHONE #:	FAX #:	

PATIENT MEDICAL HISTORY

PATIENT NAME (Please Print): _____

Please place an "X" in the appropriate boxes below to indicate **your personal** medical history:

ADD/ADHD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes	<input type="checkbox"/> No
AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prostate Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin Conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Substance Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bone Fractures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mental Illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraine Headache	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tumors or Growths	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoarthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other _____		
Drug Addiction	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Where do you work and what type of work do you do? : _____

Is your work very physical or do you sit for most of your work day? : _____

Are you currently taking any medications? If yes, please list : _____

Do you use any vitamin, herb, or mineral supplements? If yes, please list : _____

Do you have any allergies? If yes, please list : _____

Are you pregnant? If yes, what is your due date : _____

Do you live alone? If not, how many people do you live with? : _____

EXERCISE LEVEL:

- None
- Moderate
- Daily
- Heavy

WORK ACTIVITY:

- Sitting
- Standing
- Light Labor
- Heavy Labor

HABITS:

- Smoke Tobacco
- Alcohol
- Coffee/Caffeine
- High Stress Level

- Packs/Day _____
- Drinks/Week _____
- Cups/Day _____
- Reason _____

What type of exercise/sports do you enjoy? : _____

Do you practice yoga or stretch on a regular basis? If yes, how often? : _____

Do you belong to a gym or a fitness center? If yes, please list : _____

Have you had physical therapy in the past? If yes, when and why? : _____

Have you had any surgeries in the past? If yes, please list date and type: _____

I attest that the information listed above is accurate and current to the best of my knowledge:

PATIENT SIGNATURE: _____ **DATE:** _____

PRECISION PHYSICAL THERAPY & SPORTS MEDICINE

5 High Street, Suite 203, Medford, MA 02155 • Tel: (781) 395-7333 Fax: (781) 395-7331

RELEASE OF MEDICAL RECORDS & AUTHORIZATION FOR TREATMENT

1. I hereby authorize Precision Physical Therapy & Sports Medicine to perform all necessary procedures and treatments as indicated for the delivery of outpatient physical therapy services.
2. I hereby authorize Precision Physical Therapy & Sports Medicine to release or receive from hospitals, physicians, and all other health professionals or facilities involved in my care, all medical records and information pertinent to my treatment or care.
3. I hereby authorize Precision Physical Therapy & Sports Medicine to utilize contracted personnel when necessary to enhance and make complete the plan of care.
4. I hereby authorize Precision Physical Therapy & Sports Medicine to furnish my insurance carrier all medical records that pertain to my current medical condition.

Today's Date: ____/____/____

Patient Signature: _____

Printed Name: _____

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CONSENT TO PHYSICAL THERAPY SERVICES

1. I authorize the performance upon myself of examinations and/or treatments performed by or under the direction of doctors, physical therapists, physical therapy assistance or physical therapy aides employed by Precision Physical Therapy and Sports Medicine.
2. I also consent to the performance of other diagnostic and therapeutic procedures in addition to, or from those stated above, whether or not arising from presently unforeseen conditions that the doctors, physical therapists, physical therapy assistants or physical therapy aides employed by Precision Physical Therapy & Sports Medicine may consider necessary or advisable in the course of my health care.
3. The nature and purpose or the procedures, the possible alternatives, the risks involved, the possible consequences, and the possibility of complication have been explained to me by the doctors, physical therapists, physical therapy assistants or physical therapy aides employed at Precision Physical Therapy & Sports Medicine.
4. I acknowledge that no guarantee or assurance as to the results that may be obtained from the procedure has been given by the doctors, physical therapists, physical therapy assistants or physical therapy assistants or physical therapy aides employed by Precision Physical Therapy & Sports Medicine.

Today's Date: ____/____/____

Patient Signature: _____

Printed Name: _____

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CANCELLATION AND TARDINESS POLICY

Dear Patient,

Welcome to our clinic!

We will strive to provide effective and efficient therapy services for you. We find it necessary to have some policies so we can provide the best care and make it available to as many people as possible.

1. We request a 24-hour notice for cancellations. We are very busy and another patient may benefit from having your scheduled time slot.
2. Please **do not** arrive early for your appointment. We treat patients on a very tight schedule and book on 15-minute intervals. There is no need to arrive too early as you may have to wait to be treated.
3. On that same token, we try our hardest to stay on schedule. If you are going to be late, please call the office to inform us. We may not be able to accommodate patients who are greater than 15 minutes late.
4. If you fail to show up for a scheduled appointment please call us within 24 hours to confirm your next appointment. If you do not contact us we will assume that you have decided to discontinue therapy and your future appointments may be removed from the schedule.
5. All patient scheduling is done at the front desk. Please be certain to confirm all changes or cancellations with the front desk, in addition to informing your therapist.

Thank you for your cooperation regarding our clinic policies. We attempt to give patients a schedule that is consistent. Please discuss your availability with your therapist to make the best arrangements.

Today's Date: ____/____/____

Patient Signature: _____

Printed Name: _____