

PROFESSIONAL ORTHOPEDIC & SPORTS PHYSICAL THERAPY

PATIENT DATA SHEET

Acct # _____

PATIENT INFORMATION

Name (Last, First): _____
Address: _____ APT # _____
City: _____ State: _____ Zip: _____ Sex: M F
Date of Birth: _____ Social Security # _____ Phone/Cell # _____
Email Address: _____

EMPLOYMENT INFORMATION

Employer: _____ Work# _____
Address: _____ City: _____ State: _____ Zip: _____

RESPONSIBLE PARTY INFORMATION

Relation to patient: Self Spouse Parent Other
Name: _____ Phone #: _____
Address: _____ SS# _____
City: _____ State: _____ Zip: _____ Date of Birth: _____

PRIMARY INSURANCE INFORMATION

Carrier Name: _____ Phone #: _____
ID #/Claim #: _____ Group #: _____
Do you have a Health Spending Acct: Y/N If yes how much does it cover? _____

SECONDARY INSURANCE INFORMATION

Carrier Name: _____ Phone: _____
ID#/Claim #: _____ Group #: _____
Date of Birth: _____ Social Security #: _____
Name of Policy Holder: _____ Relationship: _____

INJURY/CONDITION INFORMATION

Accident type: None W/C Auto Other Accident/injury/onset date: _____
Injury/Condition: _____ Surgery: Y/N Date: _____
Referring Physician: _____ MD Phone # _____ RX DATE: _____
Address: _____

Have you or a Family member ever been treated at Professional? Y/N

If yes, which location: _____ Patient's Name: _____

Have you had physical therapy this year? Y/N If yes, for how long? _____

Have you had physical therapy for this condition? Y/N If yes, for how long? _____

How did you hear about Professional PT? _____

FOR MEDICARE PATIENTS

Have you had any home care services? Yes /No

Is anyone currently coming to your house? Yes/No Ex: nurses, home health aides, etc.

If yes, when will you be fully done with home care? _____

Do you have a home care discharge letter? Yes/No

FOR STUDENT ATHLETES

What sport do they play? _____ Were they hurt at school or on a league? Yes or No

If yes what date were they hurt? _____ Was the school/league paperwork filed? Yes or No

APPT DATE _____ TIME _____ THERAPIST _____ INITIALS/DATE _____



PATIENT MEDICAL HISTORY FORM

Name: _____
 Family Physician: _____
 Last Day Worked Due to this Injury: _____
 Is an attorney involved in this case? YES NO

Treating Physician: _____
 Date of 1st Doctors Visit For this Injury: _____
 Date Returned to Work After Injury: _____
 Were you referred to Professional PT by:
 Surgeon Rehab MD Other: _____

Have you had Surgery for this Injury? YES NO
 Type of Surgery: _____

Number of Surgeries: 1 2 3 4 Other: _____

Are You Currently Taking Any Prescription or Non-Prescription Medications: Yes No (Please List Below)

Anti-Inflammatories	Yes	No	_____
Muscle Relaxers	Yes	No	_____
Pain Medication	Yes	No	_____
Other	Yes	No	_____

Have you had any of the following medical or rehabilitative services for this injury/episode?

	YES	NO		YES	NO
Chiropractor	_____	_____	General Practitioner	_____	_____
EMG/NCV	_____	_____	CT Scan	_____	_____
Massage Therapy	_____	_____	MRI	_____	_____
Milligram	_____	_____	Neurologist	_____	_____
Occupational Therapy	_____	_____	Orthopedist	_____	_____
Physical Therapy	_____	_____	Podiatrist	_____	_____
Emergency Room Care	_____	_____	X-Rays	_____	_____

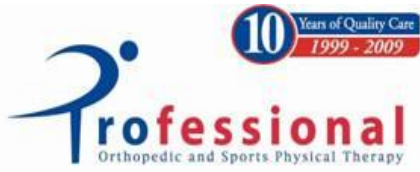
Do you now or have you ever had any of the following?

	YES	NO		YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	_____	_____	High Blood Pressure	_____	_____	Anemia	_____	_____
Shortness of Breath/Chest Pain	_____	_____	Heart Attack or Surgery	_____	_____	Diabetes	_____	_____
Coronary Heart Disease or Angina	_____	_____	Thyroid Trouble/Goiter	_____	_____	Gout	_____	_____
Cancer/chemotherapy/Radiation	_____	_____	Dizziness or Fainting	_____	_____	Weakness	_____	_____
Emotional/Psychological Problems	_____	_____	Infectious Diseases	_____	_____	Hernia	_____	_____
Bowel or Bladder Problems	_____	_____	Numbness or Tingling	_____	_____	Allergies	_____	_____
Severe or Frequent Headaches	_____	_____	Elbow/Hand Injury	_____	_____	Osteoporosis	_____	_____
Vision or Hearing Difficulties	_____	_____	Neck Injury/Surgery	_____	_____	Stroke/TIA	_____	_____
Sleeping Problems/Difficulties	_____	_____	Back Injury/Surgery	_____	_____	Blood Clot/Emboli	_____	_____
Leg/Ankle/Foot Injury/Surgery	_____	_____	Knee Injury/Surgery	_____	_____	Epilepsy/Seizures	_____	_____
Do you have a Pacemaker?	_____	_____	Arthritis/Swollen Joints	_____	_____	Varicose Veins	_____	_____
Any Pins or Metal Implants?	_____	_____	Are You Pregnant?	_____	_____	Joint Replacement	_____	_____
Weight Loss/Energy Loss	_____	_____	Do You Smoke?	_____	_____			

List any other information that would assist us in your care? _____

Are you aware of what your diagnosis is (what you're being treated for)? Yes No
 Based upon your awareness, what are your expectations/goals while in this program? _____

Patient/Guardian Signature: _____ Date: _____



Notification Policy

Name: _____

Account # _____

It is our policy not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. When returning calls and an answering machine picks up, we do not leave a message unless it is an appointment reminder. Information will not be left with an unauthorized person who may answer the phone. If you would like to have information released to someone other than yourself, please complete the following:

I authorize the staff of Professional Ortho. & Sports PT to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

- ____yes ____no Home Telephone _____
- ____yes ____no Home Answering Machine _____
- ____yes ____no Fax-Home _____
- ____yes ____no Work Telephone _____
- ____yes ____no Work Voice Mail _____
- ____yes ____no Fax-Work _____
- ____yes ____no Cell phone and Voice Mail _____

Email Address: _____

Please list names of authorized people we may leave messages with: (i.e. –spouse, boyfriend, girlfriend, parent, grandparent, etc.)

Name	Relationship	Phone number	Yes _____	No _____
Name	Relationship	Phone number	Yes _____	No _____
Name	Relationship	Phone number	Yes _____	No _____
Name	Relationship	Phone number	Yes _____	No _____

Who may we discuss your financial situation with?

Name	Relationship	Phone number	Yes _____	No _____
Name	Relationship	Phone number	Yes _____	No _____

_____SIGNATURE (patient/guardian) _____DATE



**ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES**

I, _____, (insert patient's name) acknowledge receipt on this date from PROFESSIONAL ORTHOPEDIC AND SPORTS PHYSICAL THERAPY, P.C. of a copy of the NOTICE OF PRIVACY PRACTICES of PROFESSIONAL ORTHOPEDIC AND SPORTS PHYSICAL THERAPY, P.C.

Date: _____

(Patient's Signature)

Received By:

(Internal Use Only)

(Print Name of Staff Member)

(Signature of Staff Member)