Wylie Physical Therapy

Patient Information Form

Patient Legal Name: ______________________________ *Sex:* ○M ○F
Last *First* *MI* *Preferred Name*

Address: ______________________________ *Marital Status:* ○S ○M ○D ○W
Street *City* *State* *ZipCode*

Home #: (____)________ *Cell Phone #:* (____)________ *Email Address:* ____________

Date of Birth: ________ *Social Security #:* __________ *Driver's Lic #:*__________ *State:* ____

Employer Name: ______________________________ *Work #:* (____)__________

Address: ______________________________
Street *Suite #* *City* *State* *ZipCode*

GUARANTOR (if patient is a minor) or Spouse Information or Emergency Contact

Name: ______________________________ *Relationship:* __________
Last *First* *MI*

Address: ______________________________ *Marital Status:* ○S ○M ○D ○W
Street *City* *State* *ZipCode*

Date of Birth: ________ *Social Security #:* __________ *Driver's Lic #:*__________ *State:* ____

Employer Name: ______________________________ *Work #:* (____)__________

INSURANCE INFORMATION

Primary Insurance: ______________________________ *Phone #:* (____)__________
Name of Insurance Company

Policy Holder's Name: ____________________ *ID #:* __________ *Group #:* __________

Secondary Insurance: ______________________________ *Phone #:* (____)__________
Name of Insurance Company

Policy Holder's Name: ____________________ *ID #:* __________ *Group #:* __________

PHYSICIAN INFORMATION

Family Doctor / PCP: ____________________ *Referring Physician:* ____________________

INJURY / ACCIDENT INFORMATION

Date of Injury/Onset: __________ *Injured on the job?* ○Y ○N *Automobile Accident?* ○Y ○N

CONSENT TO TREAT, RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

The undersigned consents to treatment (of minor) by Wylie Physical Therapy on an outpatient basis. I authorize Wylie Physical Therapy to release to my insurance company any information acquired in the course of my care and permit payment directly to Wylie Physical Therapy any benefits due to services rendered. I recognize and accept complete financial responsibility for any balance remaining after the payment of correct benefits.

Patient/Guardian Signature: ______________________________ *Date:* ____________

Office Use Only

Subscriber ID # ______________

Initial Health Status Form

Patient Name: ____ **Primary Language:** __________________

1. **Briefly describe your symptoms:** ____

2. **How did your symptoms start?** ____

3. **Date Symptoms began on:** ____________________ **Date of Surgery:** ____________________

4. **Is this?** ☐ Work Related ☐ Auto Related ☐ N/A

5. **How often do you experience your symptoms?**

   ① Constantly (76% - 100% of the time) ② Frequently (51% - 75% of the time)
   ③ Occasionally (26% - 50% of the time) ④ Intermittently (0% - 25% of the time)

6. **Describe the nature of your pain:**

   ☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling

7. **How is your condition changing?**

   ☐ Getting Better ☐ Not Changing ☐ Getting Worse

8. **Average pain intensity:**

   a. Last 24 hours: no pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ worst pain

   b. Past week: no pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ worst pain

9. **How much have your symptoms interfered with your usual daily activities?** (including both work outside the home and housework)

   a. no interference ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ unable to carry on any activities

10. **Check if you have difficulty:**

    ☐ Seeing ☐ Hearing ☐ Talking ☐ Memory ☐ Swallowing

11. **What is your most effective learning method:**

    ☐ Seeing ☐ Hearing ☐ Talking ☐ Doing ☐ Pictures

12. **In general, would you say your overall health right now is:**

    ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

13. **Have you had x-rays, MRI, CT scan for your area(s) of complaint?** ☐ Yes ☐ No

    Date(s) taken ___________________________ **What areas were taken?** ______________________________

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Multiple Sclerosis
☐ Urinary Problems
☐ High Blood Pressure
☐ Stroke (Date) _____________
☐ Dizziness/Fainting
☐ Head Injury

☐ Recent Fever
☐ Arthritis
☐ Diabetes
☐ Cardiac Condition
☐ Pain at Night
☐ Osteoporosis
☐ Depression

☐ Numbness (location) ______________________
☐ Seizures/Epilepsy
☐ Pacemaker
☐ Abnormal weight ☐ Gain ☐ Loss
☐ Pain unrelieved by position or rest
☐ Currently pregnant, # weeks ____
☐ Tobacco – Type: ________ Frequency _____/Day

☐ Cancer/Tumor (explain) ____
☐ Other Health Problems: (explain) ______________________________________
☐ Surgeries: ____

Office Use Only

Subscriber ID # ______________

Initial Health Status Form

14. Current Medications: ____

____

15. Who have you seen for your condition before today?

☐ No One ☐ Medical Doctor ☐ Chiropractor ☐ Massage Therapist ☐ Acupuncturist

☐ Physical Therapist ☐ Speech Therapist ☐ Occupational Therapist ☐ Other: ______________________

16. What treatment did you receive and when? ____

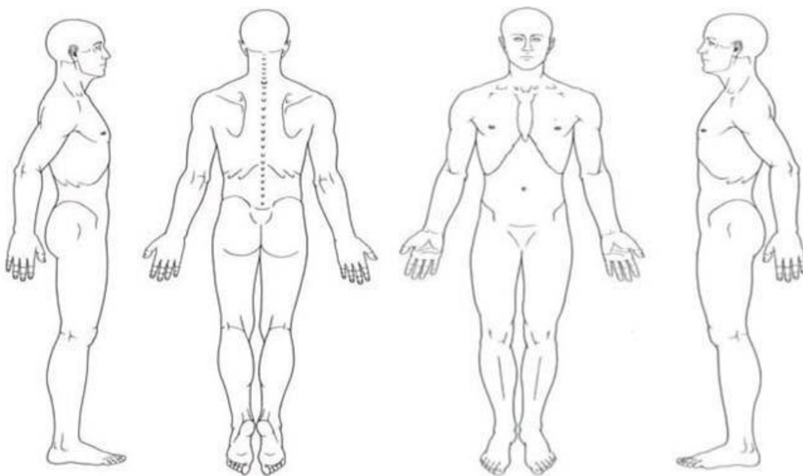
17. What is your occupation? ______________________________

18. Are you currently receiving home health? ☐ Yes ☐ No

19. What makes the problem/injury better? ____

20. What makes the problem/injury worse? ____

21. Indicate below where you have pain or other symptoms:



I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider/practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this provider/practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that this provider/practitioner may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to this provider/practitioner to contact my physician, if necessary.

I have received or I have been provided the opportunity to receive a copy of the “Notice of Privacy Practices” that explains when, where, and why my confidential health information may be used or shared.

Patient’s Full Printed Name: ____

Patient/Responsible Party Signature: ______________________________ **Date:** ________________