Patient Information (Please Print) Date:________________

Name:____**DOB:**________________________

Reason for Visit:____

Is this visit regarding post-operative care? Yes / No **If yes, date of surgery:** ____/____/________

Mailing Address: ____________________________________**City**______________**State**____**Zip**__________

Home Phone:______________________**Cell Phone:**__________________**Work Phone:**__________________

Sex:__________________________________**Email:**____

Employer: ____**Occupation:**______________________

Preferred Language: (Circle one): English Spanish Other:__________________ (please specify)

May we contact you regarding health information and updates from this clinic? Yes or No

Do you use tobacco currently? _______ Avg.daily amount: _______________

Do you currently drink alcoholic beverages?_______ Avg.Weekly amount: __________

-Primary Care Physician: ____

-Please list all known allergies: ____

Emergency Information

Contact _________________________Relationship ____________________ Phone ____________________

Address____ City ______________ State __________Zip __________

Referred By (please list name):

☐ Physician:________________ ☐Friend/Family:________________ ☐Online______________ ☐ Other:____________

AUTHORIZATION: I hereby authorize Proof Physical Therapy and Performance to furnish information requested to insurance carriers concerning my medical care. I hereby irrevocably assign to Proof Physical Therapy and Performance all payments for medical services rendered. I understand that I am financially responsible for all charges, whether or not covered by insurance. I authorize any holder of medical information about me to release to Proof Physical Therapy and Performance that information needed during the course of my treatment. By signing below I acknowledge that I have access to and agree to the terms of Proof Physical Therapy and Performance's Financial Policy, Notice of Privacy Practices and Patient Consent Form. The above information is true to the best of my knowledge. I agree that my plan of care will be discussed during my initial evaluation and I give consent for physical therapy treatment and I authorize that my insurance benefits be paid directly to the physical therapist. I understand that I am financially responsible for any balance that may be due at the end of my treatment. I also authorize Proof Physical Therapy and Performance and my insurance company to release any information required to process my claims.

Patient/Guardian Signature____ Date______________

Parent or Guardian name (Please Print)____

Patient Name____ **Date**____________________

Please list all current medications, herbals, and vitamins you are taking. Please include over the counter medication as well (use reverse if needed).

1. ______________________ 2. ______________________ 3. ______________________ 4. ______________________

Current physical activitiy / hobbies:____

Height:_______ Weight:_______ Hand Dominance: R / L Have you been here in the past 3 years? Y / N

Please list relevant past medical history (fractures, injuries, surgeries etc.) with approximate dates:

____

____

For females: Are you or do you think you may be pregnant now?_Y / N_ **Number of Children?** _____ **C-Sections?**_______

Please circle level of pain: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Extreme Pain)

Please circle your areas of pain on the diagram below: