Patient Information (Please Print)

Date: _____

Name: _____ **DOB:** _____

Mailing Address: _____ **City:** _____ **State**_____ **Zip**_____

Mobile 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

Primary Care Physician: _____

Please list all known allergies: _____

Emergency Information

Contact: _____ Relationship: _____ Phone: _____

Address: _____ City:_____ State:_____ Zip _____

How did you hear about us? (please list name):

☐ Physician: _____ ☐ Friend/Family: _____

☐ Online:_____ ☐ Other:_____

AUTHORIZATION: I hereby authorize Proof Physical Therapy and Performance, LLC to furnish information requested to insurance carriers concerning my medical care, including the processing of claims. I hereby irrevocably assign to Proof Physical Therapy and Performance, LLC all payments for medical services rendered and I authorize that my insurance benefits be paid directly to Proof Physical Therapy and Performance, LLC. I understand that I am financially responsible for all charges, whether or not covered by insurance, at the end of my treatment, and that the treating physical therapist or Proof Physical Therapy and Performance LLC may not be in network with my insurance. Payment is expected on day of treatment, unless otherwise agreed upon. I authorize any holder of medical information about me (including, but not limited to, physicians' offices, attorneys, imaging centers, and hospitals) to release to Proof Physical Therapy and Performance, LLC 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, LLC'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 to begin.

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.

_____

_____

Normal physical activity/hobbies: _____

Do you use tobacco? Yes/no Avg weekly amount:_____ Do you drink alcohol? Yes / No Avg. Weekly amount:_____

Weight: _____ **Height:** _____ Hand Dominance: R / L

Please list <u>all</u> past medical history (Chronic diseases, fractures, past injuries, surgeries etc.) with approximate dates, even if they don't affect what you are being seen here for:

_____

_____

_____

For females: Are you or do you think you may be pregnant now? Y / N **Number of Children? _____C-Sections?_____**

What are your goals from physical therapy?_____

Reason for Visit: _____

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

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: