FARNSWORTH ORTHOPEDIC PHYSICAL THERAPY
CONFIDENTIAL PATIENT INFORMATION

NAME: _____ DOB: _____ /_____ /_____ AGE: _____ GENDER: M F

ADDRESS: _____

CITY/STATE/ZIP: _____ SOCIAL SECURITY #: _____ - _____ - _____

PHONE NUMBER: _____ - _____ - _____ ☐ CELL ☐ HOME ☐ WORK ☐ OTHER: _____

PHONE NUMBER 2 (optional): _____ - _____ - _____ ☐ CELL ☐ HOME ☐ WORK ☐ OTHER: _____

MARITAL STATUS: SINGLE MARRIED WIDOWED OTHER HEIGHT: _____ WEIGHT: _____

OCCUPATION: _____ EMPLOYER: _____

REFERRING PHYSICIAN (if applicable): _____

- ***INSURANCE INFORMATION*** -

INSURANCE COMPANY: _____ ID#: _____

WHO IS THE PRIMARY INSURED? NAME: _____ DOB: _____ /_____ /_____

PHONE NUMBER OF PRIMARY INSURED: _____ - _____ - _____ INSURED's EMPLOYER: _____

PRIMARY INSURED's RELATIONSHIP TO PATIENT: SELF SPOUSE MOTHER FATHER OTHER: _____

SECONDARY INSURANCE COMPANY (if applicable): _____ ID#: _____

- ***PRIVACY AND FINANCIAL AGREEMENT*** -

I HEREBY AGREE AND GIVE MY CONSENT TO MEDICAL TREATMENT IN TREATING MY PHYSICAL CONDITION. I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NEEDED TO PROCESS MY CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES THAT ARE NOT COVERED BY MY INSURANCE. FURTHERMORE, I UNDERSTAND THAT I AM RESPONSIBLE TO INFORM THE OFFICE OF ANY CHANGES THAT OCCUR. I AUTHORIZE RELEASE OF PAYMENT DIRECTLY TO FARNSWORTH ORTHOPEDIC PHYSICAL THERAPY REGARDLESS OF PARTICIPATION IN OR OUT OF NETWORK. SHOULD I DEFAULT ON MY FINANCIAL RESPONSIBILITY AND COLLECTION ACTION IS NECESSARY, I WILL BE RESPONSIBLE FOR COLLECTION COSTS THAT ARE INCURRED. ADDITIONALLY, I ACKNOWLEDGE THAT I HAVE SEEN THE "NOTICE OF PRIVACY PRACTICES", AND I UNDERSTAND THAT I MAY ASK QUESTIONS ABOUT IT AT ANY TIME.

SIGNATURE: _____ DATE: _____

If patient is under 18, legal guardian must sign - NAME OF PARENT/GUARDIAN: _____

- ***MEDICAL HISTORY*** -

CURRENT MEDICATIONS: _____

_____

ALLERGIES: _____

PAST SURGERIES: _____

DO YOU HAVE ANY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY.

☐ ASTHMA/BRONCHITIS/EMPHYSEMA ☐ SHORTNESS OF BREATH/CHEST PAIN ☐ CORONARY HEART DISEASE
☐ PACEMAKER ☐ HIGH BLOOD PRESSURE ☐ HEART ATTACK/SURGERY ☐ STROKE/TIA ☐ BLOOD CLOT
☐ EPILEPSY/SEIZURES ☐ THYROID TROUBLE/GOITER ☐ ANEMIA ☐ CANCER OR CHEMO/RADIATION
☐ ARTHRITIS/SWOLLEN JOINTS ☐ OSTEOPOROSIS ☐ VARICOSE VEINS ☐ GOUT ☐ SLEEPING DIFFICULTIES
☐ EMOTIONAL/PSYCHOLOGICAL PROBLEMS ☐ BOWEL OR BLADDER PROBLEMS ☐ SEVERE/FREQUENT HEADACHES
☐ VISION/HEARING DIFFICULTIES ☐ DIZZINESS OR FAINTNESS ☐ DIABETES ☐ INFECTIOUS DISEASE

- ARE YOU PREGNANT? Y or N
- DO YOU SMOKE? Y or N IF YES, HOW OFTEN? _____
- DO YOU DRINK ALCOHOL? Y or N IF YES, HOW OFTEN? _____

- ***PRESENT CONDITION*** -

AREA(S) OF BODY TO BE TREATED: _____ INVOLVED SIDE: R L N/A

WHEN DID THIS CONDITION BEGIN? _____

PLEASE NOTE ANY IMAGING YOU HAVE HAD DONE FOR THIS CONDITION: MRI XRAY OTHER: _____

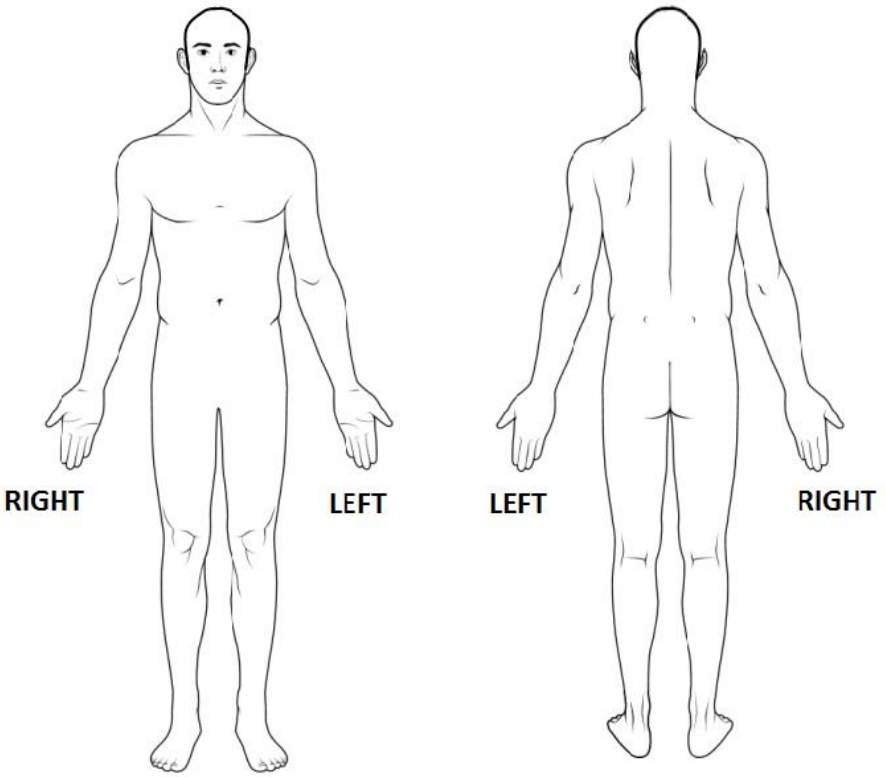
HAVE YOU HAD SURGERY FOR THIS CONDITION? Y or N IF YES, WHAT TYPE OF SURGERY? _____

DATE OF THE SURGERY (if applicable): _____

IS THIS CONDITION THE RESULT OF AN ACCIDENT? (Circle one if applicable): WORK AUTO OTHER: _____

DATE OF THE ACCIDENT/INJURY (If applicable): _____ CITY, STATE of ACCIDENT/INJURY (if applicable): _____

PLEASE INDICATE BELOW ANY AREAS WHERE YOU HAVE PAIN OR ANY OTHER SYMPTOMS:



WHICH OF THE FOLLOWING WOULD YOU USE TO DESCRIBE YOUR SYMPTOMS? CHECK ALL THAT APPLY:

☐ NUMBNESS ☐ TINGLING ☐ SHARP ☐ RADIATES ☐ SPASMS ☐ DEEP ☐ BURNS ☐ STABBING ☐ STIFF

☐ OTHER: _____

MY SYMPTOMS ARE:

☐ CONSTANT ☐ INTERMITTENT (comes and goes) ☐ OTHER: _____

PLEASE RATE YOUR CURRENT PAIN LEVEL (circle):

0	1	2	3	4	5	6	7	8	9	10