FARNSWORTH
ORTHOPEDIC PHYSICAL THERAPY

CONFIDENTIAL PATIENT INFORMATION

NAME: _____ DOB:_____ AGE: _____ GENDER: **MALE** **FEMALE**

ADDRESS: _____ UNIT/APT#:_____ CITY/STATE:_____ ZIP: _____

CELL PHONE: _____-_____- _____ ❑PERSONAL ❑OTHER: _____

OTHER PHONE: _____-_____-_____ ❑PERSONAL ❑OTHER: _____

CAN YOU RECEIVE TEXTS ON YOUR CELL PHONE? **YES** **NO** MARITAL STATUS: **SINGLE** **MARRIED** **WIDOWED** **OTHER**

OCCUPATION: _____ EMPLOYER: _____

INSURANCE INFORMATION

INSURANCE COMPANY: _____ ID#:_____ GROUP#:_____

PRIMARY INSURED: _____ DOB: _____ RELATIONSHIP TO PATIENT: _____

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

SECONDARY INSURANCE? **YES** **NO** IF SO, NAME AND ID# _____

****HAVE YOU USED YOUR INSURANCE TO HAVE PYSICAL THERAPY AT A FACILITY OTHER THAN FARNSWORTH PT WITHIN THE LAST YEAR? _____ IF YES, HOW MANY VISITS DID YOU HAVE? _____**

MEDICAL HISTORY

HEIGHT: _____ WEIGHT: _____ ALLERGIES: _____

CURRENT MEDS: _____

PAST SURGERIES: _____

PLEASE CHECK ALL THAT APPLY

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

ARE YOU PREGNANT? **YES or NO** DO YOU SMOKE?**YES:** ____ **PACK(S)/DAY or NO** DO YOU DRINK ALCOHOL? **YES:** _____ **DRINK(S) DAY or NO**

PRIVACY & FINANCIAL AGREEMENT

I 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. I also understand that I am responsible to inform the office of any changes to my personal information that may occur. I authorize release of payment directly to Farnsworth Orthopedic Physical Therapy. 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.

SIGNATURE: _____ **DATE:** _____

PRINTED NAME: _____

RELATIONSHIP TO PATIENT: _____

NAME: _____ **DOB:** _____ **TODAY'S DATE:** _____

PRESENT CONDITION

ORDERING PHYSICIAN: _____ IMAGING DONE: **MRI** **XRAY** **OTHER:**_____

AREA OF BODY TO BE TREATED: _____ INVOLVED SIDE: **RIGHT** **LEFT** **BILATERAL** **N/A**

WHEN DID YOUR SYMPTOMS START? _____

IF THIS CONDITION IS THE RESULT OF AN INJURY, WHAT TYPE OF INJURY IS IT? **SPORTS** **RECREATION** **OTHER:** _____

IF YOU HAD SURGERY FOR THIS CONDITION, WHAT IS THE DATE OF SURGERY? _____ TYPE OF SURGERY?_____

****IS THIS CONDITION THE RESULT OF AN **AUTOMOBILE** OR **WORK ACCIDENT?** **YES** or **NO** *****

IF YES:

WHAT TYPE OF ACCIDENT? **AUTO** **WORK** ACCIDENT DATE:_____ CITY/STATE:_____

PAIN LEVELS (ON A SCALE OF 0-10, 10 BEING WORST PAIN IMAGINABLE): CURRENT: _____ BEST: _____ WORST: _____

MY SYMPTOMS ARE: **CONSTANT**(75-100% OF THE TIME) **FREQUENT**(50-74% OF THE TIME) **OCCASIONAL**(26-50% OF THE TIME) **INTERMITTENT**(25% OF THE TIME)

WHICH OF THE FOLLOWING WORDS WOULD YOU USE TO DESCRIBE YOUR SYMPTOMS/PAIN? CIRCLE ALL THAT APPLY:

NUMBNESS	RADIATING	BURNING	OTHER: _____
TINGLING	SPASMS	STABBING	
SHARP	DEEP	STIFF	

PLEASE INDICATE BELOW WHERE YOU ARE HAVING PAIN OR OTHER SYMPTOMS: