KATE SCHWARTZ PHYSICAL THERAPY, LLC

PATIENT RECORD FORM AND AGREEMENT

DATE_____DATE OF INJURY_____ DATE OF BIRTH_____

PATIENT'S NAME_____MALE/FEMALE_____

_____

ADDRESS CITY STATE ZIP

PHONE: HOME_____WORK_____CELL_____

PRIMARY CARE DOCTOR_____REFERRING DOCTOR_____

HAVE YOU HAD PHYSICAL THERAPY IN THE PAST? _____WHEN?_____

Chiropractic – Occupational Therapy – Speech? _____WHEN?_____

SOCIAL SECURITY NUMBER (for billing purposes)_____

EMPLOYER_____EMPLOYER PHONE_____

EMPLOYER ADDRESS_____ OCCUPATION: _____

IS PRIMARY INSURANCE AUTO INSURANCE?_____WORKMAN'S COMP?_____

DO YOU HAVE AN ATTORNEY INVOLVED WITH YOUR INJURY?_____

IF YES, PLEASE LIST NAME, ADDRESS, and PHONE _____

_____

PRIMARY INSURANCE CO._____SUBSCRIBER'S NAME: _____

SUBSCRIBER'S DATE OF BIRTH_____RELATIONSHIP TO SUBSCRIBER_____

SECONDARY INSURANCE COMPANY_____

ARE YOU AWARE OF YOUR PHYSICAL THERAPY BENEFITS ?_____

IF NO, PLEASE INQUIRE WITH ADMINISTRATIVE STAFF

PLEASE NOTE, $40.00 WILL BE BILLED TO YOUR ACCOUNT IF OUR OFFICE IS NOT NOTIFIED OF YOUR CANCELLATION WITHOUT 24 HOURS NOTICE.

DO YOU UNDERSTAND THIS FINANCIAL RESPONSIBILITY ? _____

Your medical insurance contract is between you and your carrier. Our office will submit claims to your insurance carrier. You are responsible for any copay, coinsurance, deductible, medical supplies or modality not covered by your insurance company. **Copay is due each visit**. Referrals & authorizations for Physical Therapy are the patient's responsibility.

I understand I am responsible for all bills incurred while receiving physical therapy, including those charges not covered by my insurance. I authorize the use of this form on all insurance submissions. I authorize release of information to all my insurance cos. I authorize my physical therapist to act as my agent in helping me obtain payment from my insurance co. I authorize payment direct to my physical therapist. I permit a copy of this authorization to be used in place of the original.

***May we contact you and/or leave messages about your appointments at phone numbers listed? _____**

SIGNATURE:_____DATE: _____

Name:_____D.O.B._____Date:_____

Height:_____ Weight:_____ Age:_____R/L Handed:_____

Occupation and/or school:_____

Describe your problems/pain beginning with the most bothersome to the least:

1)_____

2)_____

3)_____

Please list operations/surgeries you've had and include dates:

_____

_____

_____

Please list any medications you are currently taking:

_____

_____

How did the present pain or injury begin? _____

_____

When? _____

Have you had any special tests done? X-rays, MRI, CT Scan, EMG, other?

_____

Where is your pain/symptoms?_____

_____

Are symptoms getting worse, getting better or staying the same? _____

What specifically increases your pain?_____

What specifically decreases your pain?_____

Are your symptoms constant? _____ intermittent? _____ Related to Activity? _____

What is your pain intensity from best to worst? (rating 1-10)?

(No pain)_____(Most pain)

best average worst

Have you had anything like this before?

Explain_____

_____

Are you currently working? (please circle):

full-time part-time modified duty unemployed disability retired

Days missed at work because of injury?_____ Out of Work Date?_____

Are there any restrictions set by your doctor? yes no Explain:_____

How does the problem interfere with your ability to work? _____

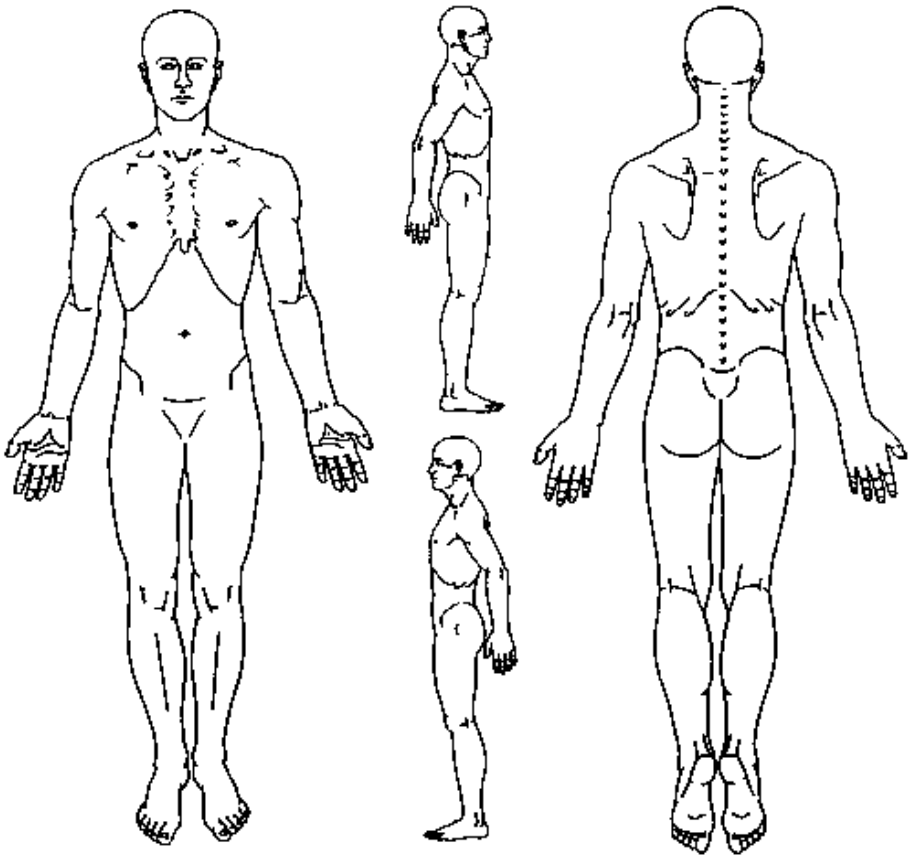
Please state the maximum amount of time you tolerate each of the following activities:

Sitting _____ Standing _____Walking _____Driving _____Passenger Driving _____

How are you at night? _____ morning? _____ late in the day? _____

PLEASE INDICATE ON THE DRAWING BELOW THE LOCATION OF YOUR SYMPTOMS

P – Pain N – Numbness T- Tingling B – Burning A - Achiness



Please check as many of the following health problems that you now have or have had:

Anemia or Blood Disease	___	Stomach/Intestinal Trouble	___	Smoker (Y/N)	_____
Heart Trouble/Murmur	___	Liver/Gallbladder Disease	___	How much day	_____
High Blood Pressure	___	Hernia	___	How long (yrs)	_____
Chest Pain/Angina	___	Diabetes/Thyroid Disease	___		
Shortness of Breath	___	Sugar/Protein in Urine	___		
Lung Disease	___	Kidney/Bladder Trouble	___	Do you drink Alcohol?	__
Allergy/Hay Fever/Asthma	___	Headaches/Migraine	___	Beer/Wine?	_____
Eye Trouble	___	Dizziness/Fainting	___	How much day/wk?	____
Deafness/Ear Trouble	___	Nervousness/Mental Illness	___		
Major Illness	___	Paralysis/Nerve Disease	___	Do you exercise regularly	
Varicose Veins/Leg Sores	___	Broken Bones	___	(at least 3 times a week)	
Cancer/Tumor/Cyst	___	Joint or Back Injury	___	YES NO	
Bone/Joint Disease	___	Arthritis/Bursitis/Ganglion	___	Doing what?	_____
Back/Disc problems	___	Recent Weight Loss/Gain	___		
Amputation Foot/Leg/Arm	___	Loss of Sight	___	Are you pregnant now?	__
Multiple Sclerosis	___	Cerebral Palsy	___	Ages of children	_____
Head Injury	___	Parkinson's Disease	___	(if any)	
Seizures/Epilepsy	___	Stroke	___		
Chronic Osteomylitis	___	Tuberculosis	___		
Phlebitis	___	Hardening of Blood Vessels	___		
Pacemaker	___	Osteoporosis	___		
Fibromyalgia	___	Anxiety/Depression	___		

Describe your major medical problems: _____

_____