Adams Physical Therapy Services, Inc

Information and Medical Form

Thank you for choosing our office! In order to serve you properly, we need the following information.
PLEASE Print or Submit Electronically. All information will remain confidential.

Patient Information. Date: _____

Name: _____ Phone: _____Alt Phone: _____ May we leave a message? Yes or No

Address: _____ City _____ State _____ Zip _____

Date of Birth:_____/_____/_____ SS#:_____ Martial Status ☐ M ☐ S Other _____ Referring MD:_____

Primary Care Physician _____ Is he/she aware of this issue? Yes or No

Date of Injury: _____Is this injury? ☐ Work Related ☐ Auto Accident How did it occur? _____

Chief Complaint:_____

List any / all medications you are currently taking: _____

Are you allergic to any medications/tapes? _____

List any surgeries:_____

Have you had any Diagnostic or Rehabilitative Services for this Injury? ☐ MRI ☐ CT Scan ☐ X-rays ☐ EMG Other:_____

Do you have any of the following?

	YES	NO
Asthma, Bronchitis or Emphysema	○	○
Shortness of Breath/Chest Pain	○	○
Coronary Heart Disease	○	○
Do you have a Pacemaker	○	○
High Blood Pressure	○	○
Heart Attack/Surgery	○	○
Stroke/TIA	○	○
Thyroid Trouble/Goiter	○	○
Diabetes	○	○
Cancer or Chemo/Radiation	○	○
Arthritis/Swollen Joints	○	○
Osteoporosis	○	○
Sleeping Difficulties	○	○
Bowel or Bladder Problems	○	○
Severe/Frequent Headaches	○	○
Are you Pregnant?	○	○

Pain or difficulty when performing the following activities?

	Mild	Moderate	Severe	Unable
Bending	☐	☐	☐	☐
Carrying	☐	☐	☐	☐
Change Pox (Sit to Stand)	☐	☐	☐	☐
Climb Stairs	☐	☐	☐	☐
Driving	☐	☐	☐	☐
Extended Computer Use	☐	☐	☐	☐
Household Chores	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Lifting	☐	☐	☐	☐
Sexual Activities	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Sitting (Prolonged)	☐	☐	☐	☐
Standing (Prolonged)	☐	☐	☐	☐
Walking	☐	☐	☐	☐

Describe your pain:

☐ Aching ☐ Burning ☐ Stabbing ☐ Pins and Needles

☐ Dull ☐ Sharp ☐ Other _____

Please rank your pain on a scale of 0-10.

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild		Moderate		Severe		Intensely Severe		Emergency Room	

Is your pain ☐ Constant / ☐ Come and Go? (Check one)

What makes your pain worse? _____

What eases your pain? _____

When is your next doctor's appt? _____ With whom? _____

How did you find out about us? _____ Have you had physical therapy before? YES ○ NO ○ When? _____

Are you aware of your Diagnosis? YES ○ NO ○ Are you aware of your Prognosis? YES ○ NO ○

Contact person in case of emergency _____ To whom may we release information? _____

Insurance Company:_____ Subscriber ID:_____ Group #:_____

Insured Employer/Address:_____ Phone:_____

Employer: _____ Occupation:_____ Work # _____ May we reach you at work? ○Yes or ○No

Responsible Party Information (If different than Patient Information)

Person responsible for this account _____ Relationship to patient _____

Address _____ Home Phone _____

SSN _____ Date of Birth _____/_____/_____

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 carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Adams Physical Therapy Services 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.
Patient/Parent/Guardian Signature:_____ Date:_____

I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient/ Parent/Guardian Signature: _____ Date: _____