DOCTORS OF PHYSICAL THERAPY

RETURNING PATIENT INFORMATION

****Please present your insurance card(s) for copying.****

Patient Name:	**Date of Birth:**	**Age:**	**Sex: M**
Social Security Number:	**Employment Status:** **Emp Unemp Retired Student**		**Marital Status:** **Single Married Other**
Address:	**City, State, Zip**		
Home Phone: OK to leave message? Yes No	**Work/Cell Phone:** OK to leave message? Yes No	**Employer:**	
Referring MD:	**Primary Care MD:**		
Emergency Contact:	**Relationship:**	**Home Phone:**	
Has there been any change in your health history since the last episode of care with us? Please explain:			

CANCELLATION POLICY and CONSENT TO TREAT

We at Doctors of Physical Therapy want to provide the best possible care for our patients and attending your scheduled appointments is a necessary part of the treatment process. Ifthere is not notice of cancellation 24 hours before the scheduled appointment, **a $50 cancellation charge will be billed directly to the patient for each cancellation. If you do not show up for a scheduled appointment, this same $50 charge will be assessed.**

By signing below, you acknowledge that you have read, understood and agree to abide by our cancellation policy as described. You also acknowledge the above patient information is correct to the best of your knowledge.

I grant permission for the staff of Doctors of Physical Therapy, APC, to perform the procedures as prescribed by my physician including a physical therapy evaluation. During this evaluation, the nature of the procedures that will be performed as well as the potential risks of care will be explained to me.

If I become ill while undergoing treatment, I give permission to the staff to administer treatments which they consider necessary to my well-being. **My signature below indicates that** I **understand and give consent to be treated as explained above.**

Patient Signature:	**Guardian's Signature:** (If patient **is <18 years old)**	**Date:**

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Patient Medical History Form-For Clinic Use ONLY

Name:	Age:	Current Concern/Problem:	**Date of Onset:**

I. Have you ever been diagnosed with any of the following conditions? FILL IN THE APPROPRIATE CIRCLES.

1. Cancer:	Yes	Type(s), include date of diagnosis:
	0	

2. Infection:	Yes	No
Chronic Urinary Tract/Kidney Infection	0	0
Pneumonia	0	0
Bone/Joint Infection	0	0
Viral Conditions:	0	0
Other Infection: (Please List)	0	0
I.		

3. Cardiovascular:	Yes	No
Heart Disease:	0	0
Deep Venous Thrombosis {DVT):	0	0
Arterial Blockage of the Legs	0	0
High Blood Pressure:	0	0
Stroke/TIA	0	0
Other:		

4. General Medical Conditions:	Yes	No
Rheumatologic Disorders:	0	0
Lung Disorders:	0	0
Liver/Kidney Conditions:	0	0
Gastrointestinal Disorders:	0	0
Neurological Disorders:	0	0
Anemia/Blood Disorders:	0	0
Thyroid Conditions:	0	0
Gout:	0	0
Diabetes:	0	0
Dermatologic Conditions:	0	0

4. General Medical Conditions:	Yes	No
Osteoarthritis: (Wear-and-Tear Arthritis)	0	0
Osteoporosis/Osteopenia:	0	0
Dizziness or falls:	0	0
Depression:	0	0
Bowel/Bladder Incontinence:	0	0
Headaches: (more than 1 per week)	0	0
Vision or hearing difficulty	0	0
Immunologic/Allergy Conditions:	0	0
Genitourinary/Gynecologic Conditions	0	0
Other conditions:		

II. **Please List All Medications Including Frequency and Dosage: (both over-the-counter and Prescribed)**

	Frequency	Dosage		Frequency	Dosage
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

III. **Surgeries and/or Hospitalizations:**	
1.	Date:
2.	Date:
3.	Date:
4.	Date:
5.	Date:

IV. Other Current Conditions:	Yes	
1. Recent, unplanned weight loss?	0	0
2. Unexplained night pain?	0	0
3. Fevers or night sweats?	0	0
4. Nausea/Vomiting?	0	0
5. Unexplained weakness or fatigue?	0	0

V. Health-Related Habits

Smoking	Yes	No		Yes	No		
If yes,< 1 pack/day?	0	0	Do you have a Pacemaker?	0	0		
If yes, > 1 pack /day?	0	0	Are you Latex Sensitive?	0	0		
Ice Sensitive?	0	0	**Heat Sensitive?**	0	0		
Previous experience with physical therapy?	0	0	**How many falls have you had in the last year?**			**Are you currently pregnant?**___	

I affirm that the above information is accurate and true.

Patient Signature_____**Date**_____**Therapist Review (Initials)**_____