WEST TEXAS PHYSICAL THERAPY PATIENT DATA SHEET						
First:	MI:	Last:				
Date of Birth:	Age:	Gender: Male Female				
Physical Address:		Mailing Address:				
Phone Numbers: O	K To Call Best	t Time To Call				
Home:						
Work:						
Cell:						
May we send you text messabove? Yes No	sages for your a	appointment reminders to the number(s) listed				
May we send you text mess the number(s) listed above	<u> </u>	eting Materials, including Patient review requests to				
By marking "Yes" above, y of unauthorized access to		that text messages may NOT be secure, with a risk				
May we send you emails relating to your care with us? Yes No By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information. Email:						
Preferred language:		Interpreter required? Yes				
Date of Injury:	R	eferring Physician:				
Injury Area:		or Work Accident: Auto Work N/A				
State Where Accident Occu	ıred:	<u> </u>				
, ,	•	eived Home Health Services Yes No No dressing, etc) in the last 60 days?				
Are you currently receiving the last 60 days?	or have you rec	eived other therapy services in Yes No				
Marital Status:						
Married Single	Divorced [Widowed Separated Unknown				
Student Status:						
Full-Time Part-Ti	me None					

EMPLOYMENT STATUS							
Employment Status: Active Military Full-Time None	Part-Time Retired Self Employed						
Employer:	Occupation:						
Address:							
Phone:							
Employer: C	Occupation:						
Address:							
Phone:							
INSURANCE INFORMATION							
Primary Insurance:							
Policy Holder's Name:	Holder's Birth Date:						
Policy or Certificate #:	Group #:						
Policy Holder's Employer:							
Secondary Insurance:							
Policy Holder's Name:	Holder's Birth Date:						
Policy or Certificate #:							
Policy Holder's Employer:							

MR #: Page: 3/4 Patient Name: How did you hear about us? **Physician** Hospital Marketing Ad - Print **Employer Cross Referral** Friend - Word of Mouth Case Manager ■ Marketing Ad - Billboard Former Patient Marketing Ad - Direct Mail - Email Attorney Adjustor Self School **Screens - Open Houses** Marketing Ad - Other ____ Specify if other: Note: Please provide us with the most updated information below. **EMERGENCY AND OTHER CONTACTS** Name Phone Work Cell Fax Туре DISCLOSURE OF MEDICAL RECORDS I authorize the following individuals to have access to my medical and billing records: Relationship Name Relationship Name

Signature of Patient

Date

PATIENT INTAKE AND CONSENT FORM

A/C Type A/C# Name Office # Internal Use Only: CONSENT TO TREATMENT I consent to rehabilitation and related services at: WEST TEXAS PHYSICAL THERAPY In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. Initials: TREATMENT OF MINORS I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. Initials: LIABILITY I know and agree that: WEST TEXAS PHYSICAL THERAPY is not responsible for loss or damage to personal valuables. Initials: **WAIVER AND RELEASE** I hereby release, discharge and acquit: WEST TEXAS PHYSICAL THERAPY its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. Initials: **AUTHORIZATION OF PAYMENT** I hereby assign all benefits directly to: WEST TEXAS PHYSICAL THERAPY I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. Initials: FINANCIAL POLICY I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. To assist in establishing your account, please: - Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information. - Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered. - Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf. Initials: NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS I acknowledge receipt of Notice of Privacy Practices. Initials: I acknowledge receipt of the Statement of Patient Rights. Initials: I certify that all of the information provided herein is true and correct. Patient/Guardian Witness Signature Signature _

Medical History Form

Patient Name:		Today's Date:				
Referring Physician:	Date of Birth:			Age:		
Primary Care Physician: Date of Inju		Date of Injury or (or Onset:			
Date of Next Physician Appointment:						
Reason for Therapy:		l				
Course of Indiana on Operate Assistant	Ata D. Marile D. Otha	If Other relea	aa avulain.			
Cause of Injury or Onset: Accident Auto Work Other: If Other, please explain:						
Have you been hospitalized for the pres	ent condition? Te	s No If Yes	, date:			
Did you have surgery for this condition If Yes, surgery type:	? 🗌 Yes 🗌 No	If Yes, date:				
Are you currently receiving any other call f Yes, please describe:	are for the condition r	nentioned above?	□Yes □No			
Have you ever received therapy in the p	past for the condition	mentioned above? [_Yes	es, date:		
Describe previous treatment:						
Previous Treatment: ☐Successful ☐Un	successful					
Have you fallen in the last year? Yes No If Yes, how many times? If Yes, were you injured? Yes No Do you worry about falling? Yes No Do you worry about falling? Yes No						
What are your personal goals/outcome	s you hope to achieve	from therapy?				
Describe your general health: Excel	lent ☐ Good ☐ Fair	☐ Poor Do yo	ou smoke or use	tobacco?		
DO YOU CURRENTLY HAVE OR HAVE A H	ISTORY OF ANY OF TH	E FOLLOWING COND	ITIONS? (check all	l that apply)		
☐ Allergies ☐ Latex ☐ Other	☐ Dizziness		☐ Kidney Problems			
☐ Anemia	☐ Epilepsy or Seizure Disorder		☐ Metal Implants			
☐ Anxiety or Panic Disorders	☐ Fainting		☐ MRSA			
☐ Arthritis ☐ OA ☐ RA	☐ Fatigue or Weakness		☐ Multiple Sclerosis			
☐ Asthma	☐ Fever or Chills		☐ Nausea / Vomiting			
☐ Use of Blood Thinners	☐ Fractures		☐ Osteoporosis			
☐ Bowel or Bladder Disorder	☐ Headaches		☐ Pacemaker			
☐ Bleeding Disorder	☐ Head Injury or Concussion		☐ Parkinson's Disease			
☐ Cancer	☐ Hearing Impairment		☐ Peripheral Vascular Disease			
☐ Chronic Cough	☐ Heart Disease or Heart Attack		☐ Respiratory or Breathing Problems			
☐ COPD	☐ Hepatitis ☐ A ☐ B ☐ C		☐ Ringing in Ears			
☐ Congestive Heart Failure	☐ Hernia		☐ Sexual Dysfunction			
☐ Currently Pregnant	☐ Blood Pressure ☐ High ☐ Low		☐ Skin Abnormalities			
☐ Deep Vein Thrombosis (DVT)	☐ HIV or AIDS		☐ Stroke or TIA			
☐ Depression	☐ Hypoglycemia		☐ Thyroid Problems			
☐ Diabetes ☐ Type I ☐ Type II	☐ Hypersensitivity to Hot or Cold		☐ Tuberculosis			
List any other medical problems and explain:						

Medical History Form

Medication List							
Name of Medication	Dosage	Frequency					
☐ Check Box if Medication List provided separately.							
1.			☐ Injection ☐ Oral ☐ Topical ☐ Other				
2.			☐ Injection ☐ Oral ☐ Topical ☐ Other				
3.			☐ Injection ☐ Oral ☐ Topical ☐ Other				
4.			☐ Injection ☐ Oral ☐ Topical ☐ Other				
5.			☐ Injection ☐ Oral ☐ Topical ☐ Other				
6.			☐ Injection ☐ Oral ☐ Topical ☐ Other				
7.			☐ Injection ☐ Oral ☐ Topical ☐ Other				
8.			☐ Injection ☐ Oral ☐ Topical ☐ Other				
9.			☐ Injection ☐ Oral ☐ Topical ☐ Other				
10.			☐ Injection ☐ Oral ☐ Topical ☐ Other				
11.			☐ Injection ☐ Oral ☐ Topical ☐ Other				
12.			☐ Injection ☐ Oral ☐ Topical ☐ Other				
Over the Counter Medications (check all that apply): Aspirin/Ibuprofen Antacids Sleeping Aids Cold Medicine: Cough Medicine Allergy Relief Laxative Diet Pills Vitamins/Herbal Supplements Other:							
Pain Scale Rate the severity of your pain by circling a box on the following scale. No Pain Worst Pain 1 2 3 4 5 6 7 8 9 10 On the Body Diagram mark where you are experiencing symptoms, right now. Use the letters below to indicate the type and location. KEY: A = Aching B = Burning N = Numbness P = Tingling S = Stabbing O = Other							
Signature of Patient:	DOB:						
Printed Name of Patient:		Date:					