

Aberdeen Physical Therapy

Please fill in all lines and print clearly!

Name: _____ Date of Birth: ___/___/___

Ordering Physician: _____ Primary Physician: _____

Home Phone: _____ Cell Phone: _____

Address: _____

City/State/Zip: _____

Person able to speak on account/emergency contact name and number: _____

With whom do you live?

Alone ___ Spouse only ___ Spouse and children ___ Children only ___ Other relatives ___
Group setting ___ Personal care attendant ___ Other _____

Employment

Working fulltime _____
Working part-time _____
Currently not working due to condition _____
Homemaker ___ Student ___ Retired ___ Unemployed ___
Occupation: _____

FINANCIAL POLICY/ AUTHORIZATION AND CONSENT FOR TREATMENT

Most misunderstandings regarding insurance coverage and payments can be avoided if you are aware of the type of insurance coverage you have. If you do not know what kind of coverage you have please check with your insurance company. This is your responsibility!!

Benefits received from your insurance carrier are not a guarantee of payment. If

after 90 days, your insurance company does not make payment, and we have sent all pertinent information needed, we will bill you and you will be responsible for collecting payment from your insurance company.

I authorize the release of any medical information necessary to process my claims with my insurance company. I authorize my insurance company to pay bills in connection with these claims directly to Aberdeen Physical Therapy & Fitness. I understand that I will be responsible for any charges that are not covered by my insurance company as well as my co-payment and deductibles at the time of service.

Signature (patient or parent/ guardian)

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. I hereby consent the use and disclosure of my health information for purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Signature (patient or parent/ guardian)

Date

LIVING ENVIRONMENT

Does your home have?

- Stairs, no railing
- Stairs, railing
- Ramps
- Elevator
- Uneven terrain

Do you use?

- Cane
- Walker
- Manual wheelchair
- Motorized wheelchair
- Glasses hearing aides
- Other: _____

Height _____ Weight _____

MEDICAL HISTORY (Have you had or do you currently have any of the following?)

- | | |
|--|---|
| <input type="checkbox"/> Asthma, Bronchitis, Emphysema | <input type="checkbox"/> Severe or Frequent Headaches |
| <input type="checkbox"/> Shortness of Breath/Chest Pain | <input type="checkbox"/> Vision or Hearing Difficulty |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Numbness or Tingling |
| <input type="checkbox"/> Do you have a Pacemaker | <input type="checkbox"/> Dizziness or Fainting |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Heart Attack/Heart Surgery | <input type="checkbox"/> Weight Loss/Energy Loss |
| <input type="checkbox"/> Blood Clot | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Thyroid Trouble |
| <input type="checkbox"/> Pins or Metal Implants | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Bowel or Bladder Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neck Injury/Pain |
| <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Shoulder Injury/Pain |
| <input type="checkbox"/> Cancer <input type="checkbox"/> Lymph nodes removed | <input type="checkbox"/> Elbow/Hand Injury/Pain |
| <input type="checkbox"/> Chemo <input type="checkbox"/> Radiation | <input type="checkbox"/> Back Injury/Pain |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Knee Injury/Pain |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Leg/Ankle/Foot Injury/Pain |
| <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Latex Allergies | <input type="checkbox"/> Parkinson's |

Other _____

MEDICATIONS PLEASE LIST AMOUNTS, FREQUENCY AND HOW ITS ADMINISTERD (ORAL, INJ, DROPS):

Have you ever had surgery? Yes _____ No _____

If yes, please describe, and include dates: _____

Have you had physical therapy inpatient or at home this calendar year? _____

Have you had physical therapy in an out patient setting this calendar year? _____

Is this due to an auto or workers comp accident? _____

Signature _____ date _____