Gainesville Physical Therapy & Wellness

"Where People Matter and Results Count"

Patient Information Page 1 of 2

*We cannot process your insurance claims without the required fields filled out.

Patient's Name*:_____ Today's Date: _____
Street address*:_____ SSN*:_____
City and State*:_____ Zip Code*:_____
Gender at Birth: _____ Gender Identity: _____
Date of Birth: _____ Age: _____ Email: _____
Primary Phone: _____ Secondary Phone: _____
Can we communicate with you about appointments, reminders, billing updates, medical records, etc. by (check all that apply): ☐ Text ☐ Email ☐ Voicemail
Referring Physician: _____ Phone Number: _____
Family Physician: _____ Phone Number:_____
Person to contact in case of emergency/authorized to speak to:_____
Contact Phone Number:_____ Relationship to patient:_____
Is emergency contact authorized to review information: ◯ Yes ◯ No

---

Primary Insurance Company Name: _____
Policy Number: _____ Group Number: _____
Insurance Company Claims Billing Address: _____
Policyholder's name:_____ Relationship to patient:_____
Policy holder's date of birth:_____ Gender on Insurance: ◯ Male ◯ Female

Secondary Insurance Company Name: _____
Policy Number:_____ Group Number: _____
Insurance Company Claims Billing Address: _____
Policyholder's name:_____ Relationship to patient:_____
Policy holder's date of birth:_____ Gender on Insurance: ◯ Male ◯ Female

Is this a Worker's Compensation Claim? ◯ Yes ◯ No
Date of Injury:_____ Company Name:_____
Claim #:_____ Address:_____
Adjustor's Name:_____ Phone Number: _____

Is this an Auto Accident Case? ◯ Yes ◯ No
Date of Accident: _____ Company Name: _____
Claim #:_____ Address: _____
Adjustor's Name:_____ Phone Number: _____

Is there a pending litigation concerning your injury? ◯ Yes ◯ NO If Yes, name of attorney_____
Address:_____ Phone Number:_____

How did you obtain our name?
◯ Friend ◯ Physician ◯ Internet ◯ Website ◯ Other:_____

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Patient Information Page 2 of 2

I consent to Gainesville Physical Therapy & Wellness, LLC for treatment/procedures that are necessary or advisable for my care. I hereby grant authorization to Gainesville Physical Therapy & Wellness, LLC to exchange with and/or release requested information regarding my medical care to my insurance carrier (s) and to:

◯ Workers Compensation ◯ Patient/Guardian ◯ Attorney ◯ Rehab Intermediary

Write the names of those you are allowing to share your information with below & place your initials next to their names.

Name:_____ Initials: _____
Name:_____ Initials: _____
Name:_____ Initials: _____

Please initial the statements below indicating agreement and understanding!

_____ I certify that the information furnished by me is correct and I hereby direct and authorize payment of health care benefits due me by insurer to Gainesville Physical Therapy & Wellness, LLC. I also certify that I have received the Policy and Procedures from Gainesville Physical Therapy & Wellness, LLC

_____ I have read and understand Gainesville Physical Therapy & Wellness, LLC's privacy notice. I further understand that I may obtain a copy of this HIPAA privacy notice upon my request.

_____ I understand that if I **no show or do not cancel my appointment 24 hours** in advance that there is a **$35 charge**, which is **NOT COVERED** by insurance. (This also applies to worker's comp patients.) I further understand that I may obtain a copy of this policy upon request.

_____ **I understand that I am financially responsible for payment of fees regardless of insurance coverage.** I understand that my insurance is my responsibility. We verify your benefits and simply relay the information obtained from your insurance company to you. GPTW is **NOT responsible** for any erroneous information your insurance company may provide. Please contact your insurance company with any questions you may have.

Clients Signature:_____ Date:_____

Responsible Party's Signature (if patient is a minor):_____

_____

Witness Print Name Witness Signature Date

4113-C NW 6th Street Gainesville, Florida 32609 P (352)-376-6300* F (352)372-0661 *gainesvillept@gmail.com**

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Patient Current Medical History Form Page 1 of 2

A complete medical history is necessary for a thorough evaluation. Please answer the following questions.

Patient Name:_____ Today's Date:_____
Date of Birth:_____ Age:_____ Height:_____ Weight:_____
Gender Identity: _____ Currently Pregnant: ◯ Yes ◯ No _____

Have you had home health in the last 90 days? ◯Yes ◯No [Agency_____]

Where/how did your injury/symptoms occur? ◯Recreation ◯Home ◯Work ◯Auto Accident ◯Surgery ◯Unknown ◯Other:_____ Date of Injury:_____

For this injury, has your medical care included (check all that apply)

◯ Yes ◯ No	Surgery	Kind?	
◯ Yes ◯ No	Injection	Where:	Did this help? ◯ Yes ◯ No
◯ Yes ◯ No	Prior PT	When:	
◯ Yes ◯ No	Home Health	When:	
◯ Yes ◯ No	Chiropractor	When:	
◯ Yes ◯ No	X-Ray	When:	
◯ Yes ◯ No	CT Scan	When:	
◯ Yes ◯ No	NCV (Nerve conduction velocity)	When:	
◯ Yes ◯ No	Exercises:		
	Other:		

Are your symptoms: ◯ Constant ◯ Intermittent ◯ Getting Better ◯ Getting Worse ◯ Same

Please rate your major area of pain on a 0-10 Pain Rating Scale by marking the number of your pain below. At present time:

Pain Scale: ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10
No Pain Worst Pain

Over the past 30 days: 0-10 what is your Lowest Pain? _____ **Highest Pain?** _____
What makes it better? _____ **Worse?** _____
Other info regarding pain: _____

_____

_____
Print Patient Name Signature Date

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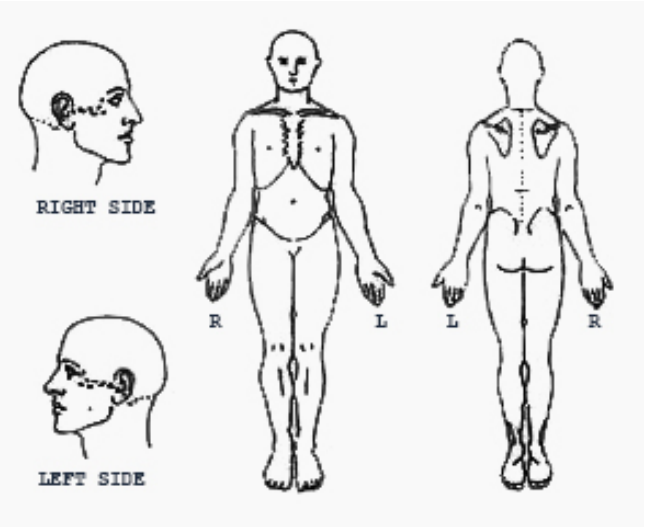
Patient Current Medical History Form Page 2 of 2

Indicate where your pain is located and what type of pain you feel at the present time. Use symbols below to describe your pain as it relates to the current injury or condition for which you seek help:

//// Stabbing
XXX Burning
000 Pins & Needles
=== Numbness
::::: Ache



What activities/tasks would you say are most affected by your area of greatest pain? What is your greatest difficulty in your daily tasks/household chores?

_____

_____

_____

What is your current activity capabilities?

Reach Overhead: ◯ unable ◯ reach mouth ◯ opposite shoulder ◯ top of head ◯ No limit
Lifting: ◯ <5 lb ◯ 5-15 lb ◯ 16-20 lb ◯ 21-25 lb ◯ 26-30 lb ◯ 31-40 lb ◯ 41-50 lb ◯ > 50 lb
Carry: ◯ <5 lb ◯ 5-15 lb ◯ 16-20 lb ◯ 21-25 lb ◯ 26-30 lb ◯ 31-40 lb ◯ 41-50 lb ◯ > 50 lb
Stand: ◯ unable due to pain ◯ < 15 min ◯ 15-60 min ◯ > 60 min ◯ No Difficulty
Sit: ◯ unable due to pain ◯ < 15 min ◯ 15-60 min ◯ > 60 min ◯ No Difficulty
Chew: ◯ unable due to pain ◯ pureed ◯ soft diet ◯ small pieces ◯ No difficulty
Sleep: ◯ unable to rest ◯ awakened> 5x/night ◯ 3-5x/ night ◯ 1-2x/night ◯ No Difficulty
Socialize: ◯ unable 96-100% ◯ 50-95% ◯ 25-49% ◯ 5-24% ◯ 0-4% limitation with activity
Headaches: ◯ 96-100% of your time ◯ 50-95% ◯ 25-49% ◯ 5-24% ◯ 0-4% of your time
Mouth Open to Eat: ◯ unable ◯ chopped/puree ◯ small size bites ◯ med bites ◯ no diff
Eye Closure: ◯ unable ◯ partial closure ◯ full closure ◯ automatic blinking ◯ no difficulty
Are you currently working? ◯ Yes ◯ No ◯ Full Duty ◯ Restricted (Hours/week _____)
What are you job responsibilities? _____
_____**Return to work date?** _____
Additional Comments:_____

_____

_____

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Patients Current Health History Page 1 of 3

I live: ◯Alone ◯Spouse Only ◯Spouse and Other(s) ◯Child (not spouse) ◯Other Relative (not spouse or child) ◯Group Setting ◯Personal Care Attendant

PAST MEDICAL HISTORY: Have you EVER been diagnosed with any of the following conditions or have you recently experienced any of the following?

◯Yes	◯No	Allergies/Asthma	◯Yes	◯No	Kidney Problems
◯Yes	◯No	Anemia	◯Yes	◯No	Metal Implants
◯Yes	◯No	Anxiety	◯Yes	◯No	MRSA
◯Yes	◯No	Arthritis (Not RA)	◯Yes	◯No	Multiple Sclerosis
◯Yes	◯No	Autoimmune Disorder	◯Yes	◯No	Muscular Disease
◯Yes	◯No	Cancer	◯Yes	◯No	Osteoporosis
◯Yes	◯No	Cardiac Conditions	◯Yes	◯No	Parkinsons
◯Yes	◯No	Cardiac Pacemaker	◯Yes	◯No	Rheumatoid Arthritis
◯Yes	◯No	Chemical Dependency	◯Yes	◯No	Seizures
◯Yes	◯No	Circulation Problems	◯Yes	◯No	Smoking
◯Yes	◯No	Depression	◯Yes	◯No	Speech Problems
◯Yes	◯No	Diabetes	◯Yes	◯No	Strokes
◯Yes	◯No	Dizzy Spells	◯Yes	◯No	Thyroid Disease
◯Yes	◯No	Emphysema/Bronchitis	◯Yes	◯No	Tuberculosis
◯Yes	◯No	Fibromyalgia	◯Yes	◯No	Vision Problems
◯Yes	◯No	Fractures	◯Yes	◯No	Polio
◯Yes	◯No	Gallbladder Problems	◯Yes	◯No	Fever/Sweats/Chills
◯Yes	◯No	Headaches	◯Yes	◯No	Nausea or Vomiting
◯Yes	◯No	Hearing Impairment	◯Yes	◯No	Weight Gain/Loss
◯Yes	◯No	Hepatitis	◯Yes	◯No	Sleep Apnea
◯Yes	◯No	High Cholesterol	◯Yes	◯No	Fatigue
◯Yes	◯No	High/Low Blood Pressure	◯Yes	◯No	Weakness
◯Yes	◯No	HIV/AIDS	◯Yes	◯No	Numbness/Tingling
◯Yes	◯No	Incontinence	Other:		

How many caffeine containing beverages do you drink per day? _____

How many days per week do you drink alcohol?_____

How many packs of cigarettes do you smoke per day?_____

Please list any allergies:_____

What kind of exercise do you do? How often? _____

_____

_____

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Patients Current Health History Page 2 of 3

Which of the following over-the-counter medications have you taken in the last week?

◯ Yes	◯ No	Asprin	◯ Yes	◯ No	Antihistamines
◯ Yes	◯ No	Tylenol	◯ Yes	◯ No	Antacid
◯ Yes	◯ No	Advil/Motrin/Ibuprofen	◯ Yes	◯ No	Decongestants
◯ Yes	◯ No	Laxatives	◯ Yes	◯ No	Vitamins/Supplements
Other:					

List Vitamins/Supplements:

_____

_____

Please list any PRESCIPTIONS you are currently taking (including Pills, Injections, etc.) and explain what they are used for.

☐ **See Attached List**

Medication	Dosage	Frequency	Route	Reason

Do any of your medications cause you to be dizzy or to lose your balance? ◯ Yes ◯ No

At the present time, would you say your health is: ◯ Excellent ◯ Very Good ◯ Fair ◯ Poor
During the past month have you been feeling down, depressed, or hopeless? ◯ Yes ◯ No
During the past month have you had little interest/pleasure in doing things? ◯ Yes ◯ No
Do you ever feel unsafe at home, been hit, or has some one tried to injure you in any way?
◯ Yes ◯ No

_____

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Patients Current Health History Page 3 of 3

Injuries, Hospitalizations, Surgeries

Please describe all injuries and any surgeries for which you have been treated:

Injury/Surgery/Hospitalization	Date	Reason

Has anyone in your immediate family (parents, brothers, sisters) been treated for any of the following?

◯ Yes	◯ No	Diabetes	◯ Yes	◯ No	Headaches
◯ Yes	◯ No	Stroke	◯ Yes	◯ No	Epilepsy
◯ Yes	◯ No	Kidney Disease	◯ Yes	◯ No	Mental Illness
◯ Yes	◯ No	Chemical Dependency (Alcoholism)	◯ Yes	◯ No	Cancer
◯ Yes	◯ No	Tuberculosis	◯ Yes	◯ No	Arthritis
◯ Yes	◯ No	Heart Disease	◯ Yes	◯ No	Anemia
◯ Yes	◯ No	High Blood Pressure	◯ Yes	◯ No	Sleep Apnea

_____

Print Patient Name Signature Date