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

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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 dizziness/vertigo on a 0-10 Pain Rating Scale by marking the number of your pain below. At present time:

Vertigo ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10
No Vertigo Worst Vertigo

Over the past 30 days: 0-10 what is your Lowest Dizziness? _____ **Highest?** _____
What makes it better? _____ **Worse?** _____

Do you or have you fallen to the ground? ◯ Yes ◯ No How Often?_____
Do you have or have you had "near falls"? ◯ Yes ◯ No Describe_____
Do you stumble, stagger, or side-step while walking? ◯ Yes ◯ No
Do you drift to one side when you walk? ◯ Yes ◯ No Towards: ◯ Right ◯ Left

_____
Print Patient Name Signature Date

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Patient Current Medical History Form Page 2 of 2

Do you experience spells of VERTIGO (sense of spinning): ◯Yes ◯ No
If yes, how long do these spells last:
◯< 60 sec ◯ > 60 sec ◯1-2 hours ◯30min -24 hours ◯48-27 hours ◯ all the time
When was the last time the vertigo occurred? _____
Is the Vertigo: ◯spontaneous ◯ induced by motion ◯ induced by position changes

Do you experience a sense of being off-balance (disequilibrium): ◯Yes ◯ No
Is the feeling of off balance:
☐constant ☐ spontaneous ☐induced by motion ☐induced by position changes
☐ worse with fatigue ☐ worse in the dark ☐ worse outside ☐ worse on uneven surfaces

Does the feeling of being off balance occur when you are:
☐lying down ☐sitting ☐ standing ☐walking

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

_____
_____
_____

What is your current activity capabilities?
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 dizzy ◯ < 15 min ◯ 15-60 min ◯ > 60 min ◯ No Difficulty
Sit: ◯ unable due to dizzy ◯ < 15 min ◯ 15-60 min ◯ > 60 min ◯ No Difficulty
Walk: ◯ unable due to dizzy ◯ < 100 yd ◯ 101-500 yd ◯ ¼ Mile ◯½ mi ◯ 1 mi ◯ Not limited
Sleep: ◯ unable to rest ◯awakened> 5x/night ◯ 3-5x/ night ◯ 1-2x/night ◯ No Difficulty
Stairs: ◯ unable to ascend ◯<10 steps ◯ 10-20 steps ◯20-30 steps ◯ 30-50 steps ◯ >50 steps
Housework: ◯ unable ◯ perform light work ◯ moderate work ◯ heavy work ◯ unlimited
Yardwork: ◯ unable ◯ minimal ◯ moderate (sweep) ◯ heavy (shoveling) ◯ unlimited
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