

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: _____

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)

<input type="radio"/> Yes	<input type="radio"/> No	Surgery	Kind?
<input type="radio"/> Yes	<input type="radio"/> No	Injection	Where: _____ Did this help? <input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Yes	<input type="radio"/> No	Prior PT	When: _____
<input type="radio"/> Yes	<input type="radio"/> No	Home Health	When: _____
<input type="radio"/> Yes	<input type="radio"/> No	Chiropractor	When: _____
<input type="radio"/> Yes	<input type="radio"/> No	X-Ray	When: _____
<input type="radio"/> Yes	<input type="radio"/> No	CT Scan	When: _____
<input type="radio"/> Yes	<input type="radio"/> No	NCV (Nerve conduction velocity)	When: _____
<input type="radio"/> Yes	<input type="radio"/> 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: _____

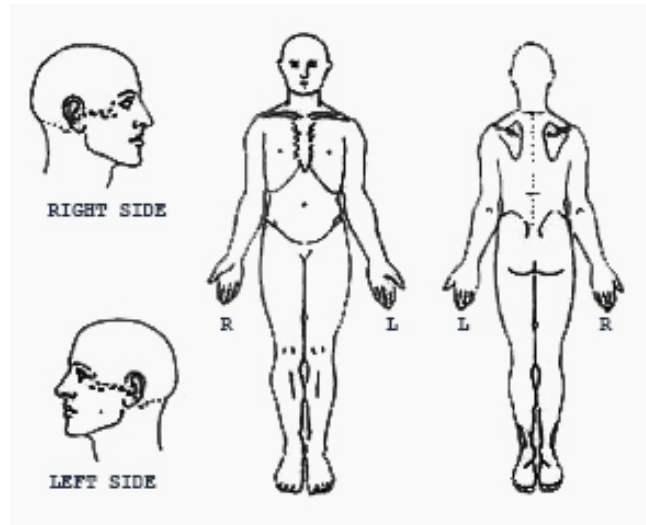
Print Patient Name

Signature

Date

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
- Walk: unable due to pain < 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: _____

Print Patient Name

Signature

Date

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?

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

Print Patient Name

Signature

Date

Patients Current Health History Page 2 of 3

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

<input type="radio"/> Yes	<input type="radio"/> No	Asprin	<input type="radio"/> Yes	<input type="radio"/> No	Antihistamines
<input type="radio"/> Yes	<input type="radio"/> No	Tylenol	<input type="radio"/> Yes	<input type="radio"/> No	Antacid
<input type="radio"/> Yes	<input type="radio"/> No	Advil/Motrin/Ibuprofen	<input type="radio"/> Yes	<input type="radio"/> No	Decongestants
<input type="radio"/> Yes	<input type="radio"/> No	Laxatives	<input type="radio"/> Yes	<input type="radio"/> No	Vitamins/Supplements
Other:					

List Vitamins/Supplements:

Please list any PRESCRIPTIONS 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

Print Patient Name

Signature

Date

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?

<input type="radio"/> Yes <input type="radio"/> No Diabetes	<input type="radio"/> Yes <input type="radio"/> No Headaches
<input type="radio"/> Yes <input type="radio"/> No Stroke	<input type="radio"/> Yes <input type="radio"/> No Epilepsy
<input type="radio"/> Yes <input type="radio"/> No Kidney Disease	<input type="radio"/> Yes <input type="radio"/> No Mental Illness
<input type="radio"/> Yes <input type="radio"/> No Chemical Dependency (Alcoholism)	<input type="radio"/> Yes <input type="radio"/> No Cancer
<input type="radio"/> Yes <input type="radio"/> No Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No Arthritis
<input type="radio"/> Yes <input type="radio"/> No Heart Disease	<input type="radio"/> Yes <input type="radio"/> No Anemia
<input type="radio"/> Yes <input type="radio"/> No High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No Sleep Apnea

Print Patient Name

Signature

Date