



**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@Birth: \_\_\_\_\_  
 Gender Identity: \_\_\_\_\_ Preferred Pronouns: \_\_\_\_\_  
 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: \_\_\_\_\_ Policyholder's name (if not patient): \_\_\_\_\_  
 Relationship to patient: \_\_\_\_\_ Policy holder's date of birth: \_\_\_\_\_  
 Gender on Insurance:  Male  Female

**Secondary Insurance Company Name:** \_\_\_\_\_  
 Policy Number: \_\_\_\_\_ Policyholder's name (if not patient): \_\_\_\_\_  
 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 #: \_\_\_\_\_ Adjustor's Name: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_

**Is this an Auto Accident Case?**  Yes  No  
 Date of Accident: \_\_\_\_\_ Company Name: \_\_\_\_\_  
 Claim #: \_\_\_\_\_ Adjustor's Name: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_

Do you have an attorney concerning your injury?  Yes  No If Yes, name of attorney \_\_\_\_\_  
 Law Office: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Have you had home health in the last 90 days?**  Yes  No Agency: \_\_\_\_\_

**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: \_\_\_\_\_

**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

## Patient Current Medical History Form Page 1 of 2

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

**Currently Pregnant:**  Yes  No **Months:** \_\_\_\_\_

**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)**

Have you had any of these?		When or Where?	Did it help?	
<input type="radio"/> Yes	<input type="radio"/> No	Surgery	Kind:	<input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Yes	<input type="radio"/> No	Injection	Where:	<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
<input type="radio"/> Yes	<input type="radio"/> No	Home Health	When:	<input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Yes	<input type="radio"/> No	Chiropractor	When:	<input type="radio"/> Yes <input type="radio"/> No
<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	MRI	When:	
<input type="radio"/> Yes	<input type="radio"/> No	Nerve conduction	When:	
<input type="radio"/> Yes	<input type="radio"/> No	Exercises:		
		Other:		

**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  Light Duty (weight restriction \_\_\_\_\_)

**What are you job responsibilities?** \_\_\_\_\_  
**Return to work date?** \_\_\_\_\_

**Additional Comments:** \_\_\_\_\_

Print Patient Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

## Patient Current Medical History Form Page 2 of 2

**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?** \_\_\_\_\_

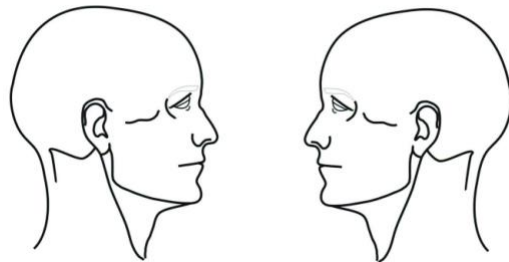
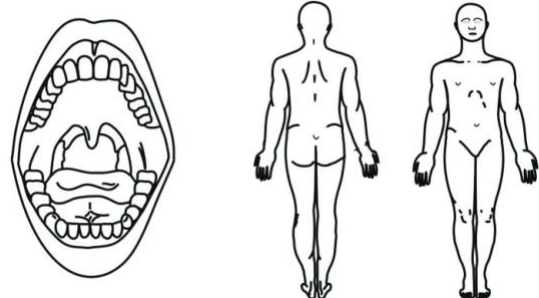
**What makes it better?** \_\_\_\_\_ **Worse?** \_\_\_\_\_

**Do you have clicking?**  No  Yes **Which Side:**  Right  Left  Both

**Other info regarding pain/clicking:** \_\_\_\_\_

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?**

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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

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

Over the Counter:  Aspirin  Advil/Motrin/Ibuprofen  Aleve  Tylenol/Acetaminophen  
 Do any of your medications cause you to be dizzy or to lose your balance?  Yes  No

List Vitamins/Supplements:

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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

