



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: _____

GPTW may contact me by phone, email, or text. I understand that these forms of communication are not secure and accept any risk involved in using them.

- Initial here _____ **ONLY** if you want to request that all communications from GPTW be via fax or United States mail only. Fax #: _____

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: _____ Policyholder's date of birth: _____

Secondary Insurance Company Name: _____
Policy Number: _____ Policyholder's name (if not patient): _____
Relationship to patient: _____ Policyholder's date of birth: _____

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 Attorney: _____
Law Office: _____ Phone: _____ Fax: _____

Have you had home health in the last 90 days? Yes No Agency: _____

You must be discharged from home health before your insurance will cover our PT claims

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

"Where You Matter and Your Results Count"



Patient Information Page 2 of 2

I authorize to Gainesville Physical Therapy & Wellness, LLC to provide 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 read and understand the Policies and Procedures as well as the Privacy Notice from Gainesville Physical Therapy & Wellness, LLC and that I may obtain a copy upon my request (located on the website under Forms).

_____ I understand that if I **NO SHOW** or do not **CANCEL** my appointment **24 hours** in advance that there is a **\$50 charge**, which is **NOT COVERED** by insurance.

_____ 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 as a courtesy to you 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 Printed 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
 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 |
| <input type="radio"/> Yes | <input type="radio"/> No | CT Scan | When: | <input type="radio"/> Yes <input type="radio"/> No |
| <input type="radio"/> Yes | <input type="radio"/> No | MRI | When: | <input type="radio"/> Yes <input type="radio"/> No |
| <input type="radio"/> Yes | <input type="radio"/> No | Nerve conduction | When: | <input type="radio"/> Yes <input type="radio"/> No |
| <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

"Where You Matter and Your Results Count"



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? _____

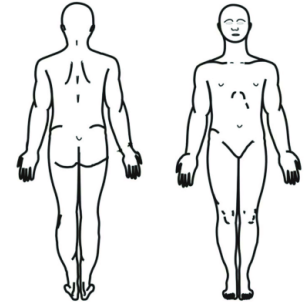
What makes it better? _____ Worse? _____

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

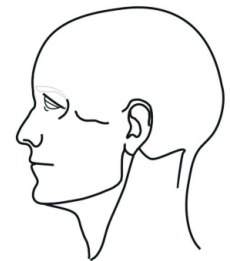
Other info regarding pain/clicking: _____

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?



Patient Name

Signature

Date

"Where You Matter and Your Results Count"



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 | <input type="radio"/> Yes <input type="radio"/> No | Incontinence |
| <input type="radio"/> Yes <input type="radio"/> No | Anemia | <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems |
| <input type="radio"/> Yes <input type="radio"/> No | Anxiety | <input type="radio"/> Yes <input type="radio"/> No | Metal Implants |
| <input type="radio"/> Yes <input type="radio"/> No | Arthritis (Not RA) | <input type="radio"/> Yes <input type="radio"/> No | MRSA |
| <input type="radio"/> Yes <input type="radio"/> No | Asthma | <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 | COVID19 | <input type="radio"/> Yes <input type="radio"/> No | Speech Problems |
| <input type="radio"/> Yes <input type="radio"/> No | Depression | <input type="radio"/> Yes <input type="radio"/> No | Strokes |
| <input type="radio"/> Yes <input type="radio"/> No | Diabetes | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease |
| <input type="radio"/> Yes <input type="radio"/> No | Dizzy Spells | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis |
| <input type="radio"/> Yes <input type="radio"/> No | Emphysema/Bronchitis | <input type="radio"/> Yes <input type="radio"/> No | Vision Problems |
| <input type="radio"/> Yes <input type="radio"/> No | Fibromyalgia | <input type="radio"/> Yes <input type="radio"/> No | Polio |
| <input type="radio"/> Yes <input type="radio"/> No | Fractures | <input type="radio"/> Yes <input type="radio"/> No | Fever/Sweats/Chills |
| <input type="radio"/> Yes <input type="radio"/> No | Gallbladder Problems | <input type="radio"/> Yes <input type="radio"/> No | Nausea or Vomiting |
| <input type="radio"/> Yes <input type="radio"/> No | Headaches | <input type="radio"/> Yes <input type="radio"/> No | Weight Gain/Loss |
| <input type="radio"/> Yes <input type="radio"/> No | Hearing Impairment | <input type="radio"/> Yes <input type="radio"/> No | Sleep Apnea |
| <input type="radio"/> Yes <input type="radio"/> No | Hepatitis | <input type="radio"/> Yes <input type="radio"/> No | Fatigue |
| <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol | <input type="radio"/> Yes <input type="radio"/> No | Weakness |
| <input type="radio"/> Yes <input type="radio"/> No | High/Low Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Numbness/Tingling |
| <input type="radio"/> Yes <input type="radio"/> No | HIV/AIDS | 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

"Where You Matter and Your Results Count"



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 |
|------------|--------|-----------|-------|--------|
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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:

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 |
|--------------------------------|------|--------|
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Print Patient Name

Signature

Date