GAINESVILLE PHYSICAL THERAPY & Wellness

Gainesville Physical Therapy & Wellness
4113 NW 6th St. Ste C
Gainesville, Fl 32609
P: 352-376-6300
F: 352-372-0661

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

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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:_____

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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

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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;

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?	
◯ Yes	◯ No	Surgery	Kind:	◯ Yes	◯ No
◯ Yes	◯ No	Injection	Where:	◯ Yes	◯ No
◯ Yes	◯ No	Prior PT	When:	◯ Yes	◯ No
◯ Yes	◯ No	Home Health	When:	◯ Yes	◯ No
◯ Yes	◯ No	Chiropractor	When:	◯ Yes	◯ No
◯ Yes	◯ No	X-Ray	When:	◯ Yes	◯ No
◯ Yes	◯ No	CT Scan	When:	◯ Yes	◯ No
◯ Yes	◯ No	MRI	When:	◯ Yes	◯ No
◯ Yes	◯ No	Nerve conduction	When:	◯ Yes	◯ No
◯ Yes	◯ 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
Driving: ◯ 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
Deskwork: ◯ unable ◯ <15 min ◯ 15-60 min ◯ > 60 min ◯ No Difficulty
Housework: ◯ unable ◯ perform light work ◯ moderate work ◯ heavy work ◯ unlimited
Yardwork: ◯ unable ◯ minimal ◯ moderate (sweep) ◯ heavy (shoveling) ◯ unlimited

_____

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Patient Current Medical History Form Page 2 of 2

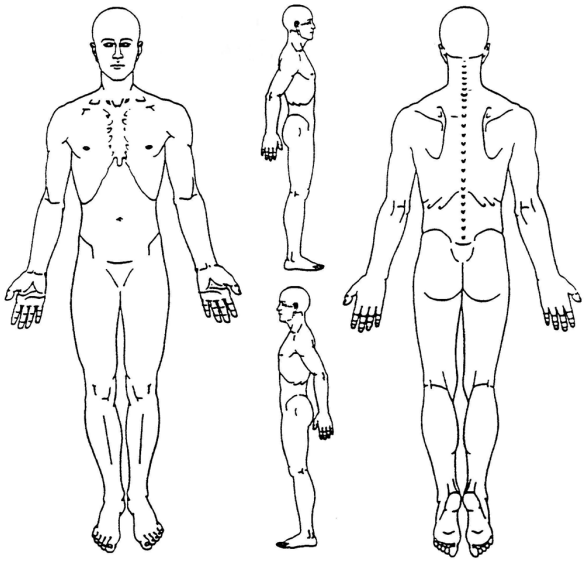
Are you currently working? ◯Yes ◯No ◯Full Duty ◯Light Duty (weight restriction_____)
What are your job responsibilities? _____
_____**Return to work date?** _____
Additional Comments:_____

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: _____

_____

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 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	◯ Yes	◯ No	Incontinence
◯ Yes	◯ No	Anemia	◯ Yes	◯ No	Kidney Problems
◯ Yes	◯ No	Anxiety	◯ Yes	◯ No	Metal Implants
◯ Yes	◯ No	Arthritis (Not RA)	◯ Yes	◯ No	MRSA
◯ Yes	◯ No	Asthma	◯ Yes	◯ No	Multiple Sclerosis
◯ Yes	◯ No	Autoimmune Disorder	◯ Yes	◯ No	Muscular Disease
◯ Yes	◯ No	Cancer	◯ Yes	◯ No	Osteoporosis
◯ Yes	◯ No	Cardiac Conditions	◯ Yes	◯ No	Parkinson's
◯ Yes	◯ No	Cardiac Pacemaker	◯ Yes	◯ No	Rhuematoid Arthritis
◯ Yes	◯ No	Chemical Dependency	◯ Yes	◯ No	Seizures
◯ Yes	◯ No	Circulation Problems	◯ Yes	◯ No	Smoking
◯ Yes	◯ No	COVID19	◯ Yes	◯ No	Speech Problems
◯ Yes	◯ No	Depression	◯ Yes	◯ No	Strokes
◯ Yes	◯ No	Diabetes	◯ Yes	◯ No	Thyroid Disease
◯ Yes	◯ No	Dizzy Spells	◯ Yes	◯ No	Tuberculosis
◯ Yes	◯ No	Emphysema/Bronchitis	◯ Yes	◯ No	Vision Problems
◯ Yes	◯ No	Fibromyalgia	◯ Yes	◯ No	Polio
◯ Yes	◯ No	Fractures	◯ Yes	◯ No	Fever/Sweats/Chills
◯ Yes	◯ No	Gallbladder Problems	◯ Yes	◯ No	Nausea or Vomiting
◯ Yes	◯ No	Headaches	◯ Yes	◯ No	Weight Gain/Loss
◯ Yes	◯ No	Hearing Impairment	◯ Yes	◯ No	Sleep Apnea
◯ Yes	◯ No	Hepatitis	◯ Yes	◯ No	Fatigue
◯ Yes	◯ No	High Cholesterol	◯ Yes	◯ No	Weakness
◯ Yes	◯ No	High/Low Blood Pressure	◯ Yes	◯ No	Numbness/Tingling
◯ Yes	◯ 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? _____
_____

_____

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Patient Current Health History Page 2 of 3

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: Oral, Nasal, Inject, etc.	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:

_____

_____

_____

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 someone 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

Print Patient Name Signature Date