



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

What activities are you currently **NOT ABLE** to do because of your problem? \_\_\_\_\_

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

When did this problem begin? \_\_\_\_\_ The problem is:  Getting better  Worse  Same

1. Bladder Leakage Frequency:

Never  Only with strong cough or sneeze  Only premenstrual

Number of Episodes: per week \_\_\_\_\_ Per day: \_\_\_\_\_

2. Severity of leakage:

No leakage  Few Drops  Wets Underwear  Wets Outerwear

3. Protection Worn

None  Tissue paper or paper towel  Panty Shields  Mini pads  Maxi pads  Max Brief

4. Leakage caused by or increased by: (select all that apply)

<input type="radio"/> Vigorous activity or exercise (running, weight lifting, cough/sneeze/laugh)	<input type="radio"/> Intercourse or sexual activity
<input type="radio"/> Light activity (walking, light house work)	<input type="radio"/> No activity changes leakage (constant)
<input type="radio"/> Changing positions (sitting or standing)	<input type="radio"/> After emptying bladder
<input type="radio"/> Walking to the toilet	<input type="radio"/> Washing hands
<input type="radio"/> Strong urge to go	<input type="radio"/> Putting key in lock
Other: _____	

5. Position or activity with leakage?  Lying Down  Sitting  Standing  Squatting

6. Fluid Intake (one glass is 8oz or one cup)

# of glasses per day: \_\_\_\_\_

# of caffeinated glasses per day: \_\_\_\_\_

# of alcoholic beverages per day: \_\_\_\_\_

Patient Name

Signature

Date

## Patient Current Medical History Form Page 2 of 2

### Bladder Habits

1. How often do you urinate during the day? \_\_\_\_\_ # of times a day
2. How often do you urinate after going to bed? \_\_\_\_\_ # of times a day
3. Do you take your time to go to the toilet and empty your bladder?  Yes  No
4. Number of bladder infections in the last year? \_\_\_\_\_
5. Can you stop the flow of urine when on the toilet?  Yes  No
6. Is the volume of urine passed usually?  Large  Average  Small  Very Small
7. Do you have the sensation that you need to go to the toilet?  Yes  No
8. Do you strain to pass urine?  Yes  No
9. Do you empty your bladder frequently, before you experience the urge to pass urine?  
 Yes  No
10. Do you have the feeling your bladder is still full after urinating?  Yes  No
11. Do you have a slow hesitant urinary stream?  Yes  No
12. Do you have difficulty initiating the urine stream?  Yes  No
13. Do you have a "trigger" that make you feel like you can't wait to go to the toilet? (running water, etc)  Yes  No Please List: \_\_\_\_\_
14. How long can you delay the need to urinate?  
 Not at all  1-2 min  3-10 min  11-30 min  31-60 min  \_\_\_\_ Hours

### Bowel Habits

15. Frequency of bowel movements: \_\_\_\_\_ per day \_\_\_\_\_ per week
16. Consistency of stool:  Loose  Normal  Hard
17. History of constipation?  Yes  No
18. Do you currently strain to go?  Yes  No
19. Do you ignore the urge to defecate?  Yes  No
20. Do you have trouble making it to the toilet on time when you have to go?  Yes  No

Past level of function: BEFORE this problem	Present level of function: WITH this problem
<input type="radio"/> Normal and unrestricted	<input type="radio"/> Normal and unrestricted
<input type="radio"/> Minimally restricted	<input type="radio"/> Minimally restricted
<input type="radio"/> Moderately restricted	<input type="radio"/> Moderately restricted
<input type="radio"/> Severely restricted	<input type="radio"/> Severely restricted
<input type="radio"/> Only heavy activities are restricted	<input type="radio"/> Only heavy activities are restricted

\_\_\_\_\_  
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

