



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 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
<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
 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

Print Patient Name

Signature

Date

"Where You Matter and Your Results Count"



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:

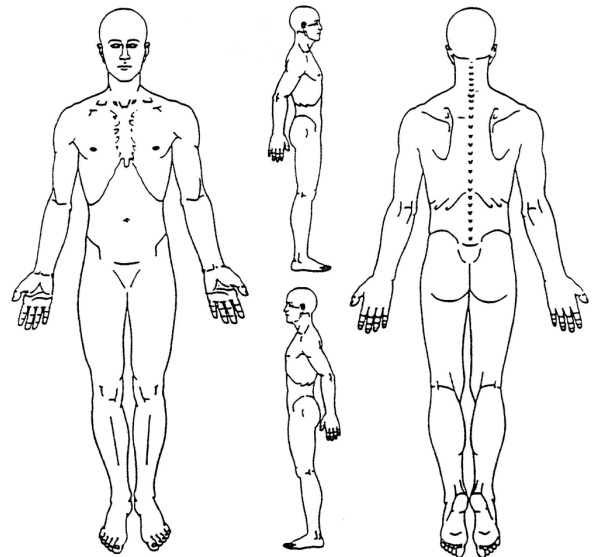
//// Stabbing

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?

Patient Name

Signature

Date



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?

<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	Parkinson's
<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

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Patient 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: 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

Print Patient Name _____ Signature _____ Date _____

