



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"



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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



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:		

Are your symptoms: Constant Intermittent Getting Better Getting Worse Same

Please rate your dizziness/vertigo on a 0-10 Pain Rating Scale by marking the number of your dizzy below. At present time:

Dizzy Scale: 0 1 2 3 4 5 6 7 8 9 10
 No Vertigo Worst Vertigo

Over the past 30 days: 0-10 what is your Lowest Dizziness? _____ Highest? _____

What makes it better? _____ Worse? _____

Do you or have you fallen to the ground? Yes No How Often? _____

Do you have or have you had "near falls"? Yes No Describe _____

Do you stumble, stagger, or side-step while walking? Yes No

Do you drift to one side when you walk? Yes No Towards: Right Left

Print Patient Name

Signature

Date

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Patient Current Medical History Form Page 2 of 2

Do you experience spells of VERTIGO (sense of spinning): Yes No

If yes, how long do these spells last:

< 60 sec > 60 sec 1-2 hours 30min -24 hours 48-27 hours all the time

When was the last time the vertigo occurred? _____

Is the Vertigo: Spontaneous Induced by motion Induced by position changes

Sneezing Occur with loud noises

Do you experience a sense of being off-balance (disequilibrium): Yes No

Is the feeling of off balance:

constant spontaneous induced by motion induced by position changes

worse with fatigue worse in the dark worse outside worse on uneven surfaces

Does the feeling of being off balance occur when you are:

lying down sitting standing walking

What activities/tasks would you say are most affected by your vertigo/dizziness? What is your greatest difficulty in your daily tasks/household chores?

What is your current activity capabilities?

Bed Mobility Dizzy: 0/10 1-2/10 3-5/10 6-9/10 10/10

Lying to Sit to Stand Dizzy: 0/10 1-2/10 3-5/10 6-9/10 10/10

Head Movement Dizzy: 0/10 1-2/10 3-5/10 6-9/10 10/10

Stand: unable due to dizzy < 15 min 15-60 min > 60 min No Difficulty

Sit: unable due to dizzy < 15 min 15-60 min > 60 min No Difficulty

Walk: unable due to dizzy < 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

Housework: unable perform light work moderate work heavy work unlimited

Yardwork: unable minimal moderate (sweep) heavy (shoveling) unlimited

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



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

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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:

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

