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*:_______________________________________ City and State*:__________________

Zip Code*:_____________ SSN:_____________ 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 Physican: ____________________________ Phone Number: ______________________________
Family Physican: _______________________________ Phone Number:______________________________
Person to contact in case of emergency/authorized to speak to:______________________________
ContactPhone 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:_________________________________

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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

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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 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 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

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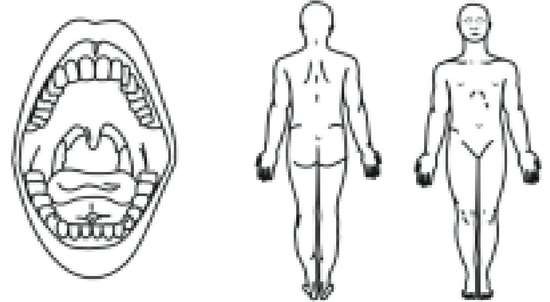
Patient Current Medical History Form Page 2 of 2

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: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain



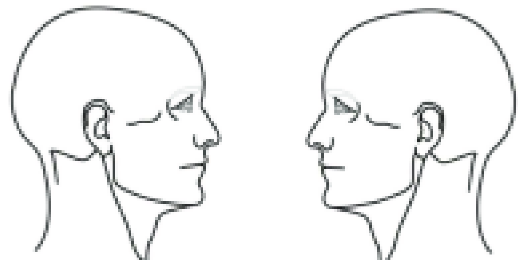
Over the past 30 days: 0-10 what is your Lowest Pain? ____________________

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?

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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?

Yes / No Allergies	Yes / NoIncontinence
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 Parkinsons
Yes / No Cardiac Pacemaker	Yes / No Rheumatoid 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?

____

____

_ 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

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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

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