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: ________
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:________________ Policy holder's date of birth: ________________

Secondary Insurance Company Name: _________________________________
Policy Number: ____________________Policyholder's name (if not patient): ____________
Relationship to patient:________________ Policy holder'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 attorny 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: ________________

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"

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 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. (Located on the website under "forms".)

__________ 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. (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 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

"*Where You Matter and Your Results Count*"

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 Current Medical History Form

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:			

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

"Where You Matter and Your Results Count"

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 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

"Where You Matter and Your Results Count"

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

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/Asthma	◯ Yes	◯ No	Kidney Problems
◯ Yes	◯ No	Anemia	◯ Yes	◯ No	Metal Implants
◯ Yes	◯ No	Anxiety	◯ Yes	◯ No	MRSA
◯ Yes	◯ No	Arthritis (Not RA)	◯ 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	Depression	◯ Yes	◯ No	Speech Problems
◯ Yes	◯ No	Diabetes	◯ Yes	◯ No	Strokes
◯ Yes	◯ No	Dizzy Spells	◯ Yes	◯ No	Thyroid Disease
◯ Yes	◯ No	Emphysema/Bronchitis	◯ Yes	◯ No	Tuberculosis
◯ Yes	◯ No	Fibromyalgia	◯ Yes	◯ No	Vision Problems
◯ Yes	◯ No	Fractures	◯ Yes	◯ No	Polio
◯ Yes	◯ No	Gallbladder Problems	◯ Yes	◯ No	Fever/Sweats/Chills
◯ Yes	◯ No	Headaches	◯ Yes	◯ No	Nausea or Vomiting
◯ Yes	◯ No	Hearing Impairment	◯ Yes	◯ No	Weight Gain/Loss
◯ Yes	◯ No	Hepatitis	◯ Yes	◯ No	Sleep Apnea
◯ Yes	◯ No	High Cholesterol	◯ Yes	◯ No	Fatigue
◯ Yes	◯ No	High/Low Blood Pressure	◯ Yes	◯ No	Weakness
◯ Yes	◯ No	HIV/AIDS	◯ Yes	◯ No	Numbness/Tingling
◯ Yes	◯ 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

"Where You Matter and Your Results Count"

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

Patients 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	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

"Where You Matter and Your Results Count"

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

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

"Where You Matter and Your Results Count"