



**PATIENT INFORMATION**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Married: \_\_\_\_\_ Single: \_\_\_\_\_ Widowed: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ (Appointment Reminders)

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_ Business Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**IF PATIENT IS INSURED THROUGH SPOUSE/PARENT, COMPLETE THIS SECTION**

Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

**HOW DID YOU HEAR ABOUT US?**

\_\_\_\_\_ Doctor Referral \_\_\_\_\_

\_\_\_\_\_ Personal Referral \_\_\_\_\_

\_\_\_\_\_ Ad/Marketing/Internet \_\_\_\_\_

\_\_\_\_\_ Other \_\_\_\_\_

**OVER →**

**EMERGENCY CONTACT INFORMATION**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**IF DUE TO WORK OR AUTO ACCIDENT, COMPLETE THIS SECTION**

Is this a liability injury? Yes \_\_\_\_\_ No \_\_\_\_\_ Date of Injury: \_\_\_\_\_

If yes, please check one: Work Comp \_\_\_\_\_ Auto \_\_\_\_\_ Other \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Claim #: \_\_\_\_\_

**\*\*MEDICARE PATIENTS\*\***

Have you had any therapy or nursing services in your home this year? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, have you been discharged from their services? Yes \_\_\_\_\_ No \_\_\_\_\_

Who was the provider? \_\_\_\_\_ Discharge Date: \_\_\_\_\_

# MEDICAL INFORMATION

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Reason for therapy: \_\_\_\_\_ Date Symptoms Began: \_\_\_\_\_

Referring Physician Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Have you **EVER** been diagnosed with any of the following? *(Please circle all that apply.)*

- |                     |                       |                     |
|---------------------|-----------------------|---------------------|
| Cancer              | Blood Clots           | Asthma              |
| Hepatitis           | Thyroid Problems      | COPD/Emphysema      |
| Stroke              | Rheumatoid Arthritis  | Osteoporosis        |
| Seizures            | Stomach Ulcers        | Osteoarthritis      |
| High Blood Pressure | Circulation Problems  | Depression          |
| Heart Problems      | Kidney Problems       | Chemical Dependency |
| Tuberculosis        | Bleeding Disorder     | Multiple Sclerosis  |
| Diabetes            | Tobacco Use: YES / NO | Amount/Day: _____   |
| Other: _____        |                       |                     |

Please list any surgeries and approximate dates:

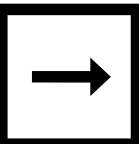
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Please list all prescription/over-the-counter/vitamins/herbal supplements currently taking:

Name	Dose/Frequency	Method (Oral/Injection/Patch)



**Pain Assessment:**

1. Please rate your pain on a scale of 0 - 10

*(0 = No pain, 10 = Pain requires immediate/emergency medical attention)*

Current Pain: \_\_\_\_\_ Best in Last Week: \_\_\_\_\_ Worst in Last Week: \_\_\_\_\_

3. How would you describe your pain? *(Please circle all that apply.)*

Sharp                      Dull                      Ache                      Stabbing/Burning

Constant                      Intermittent                      Other: \_\_\_\_\_

4. Complete the following statements:

My pain is made worse by: \_\_\_\_\_

My pain improves with: \_\_\_\_\_

I take the following medications for pain: \_\_\_\_\_

**Fall Assessment:**

1. Have you had any falls in the last year?                      YES                      NO

If yes, how many times? \_\_\_\_\_

2. Were you injured?                      YES                      NO

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**CONSENT/HIPAA/AUTHORIZATION TO RELEASE INFO/FINANCIAL AGREEMENT**

**Consent for Treatment:**

I hereby authorize and give my consent to Luke Carlson Physical Therapy and Sports Medicine to provide me with therapy services including, but not limited to, Physical and Occupational Therapy.

**Notice of Privacy Practices:**

I acknowledge that I have been given an opportunity to receive and/or read the HIPAA Notice of Privacy Practices for Luke Carlson Physical Therapy & Sports Medicine.

**Authorized Person(s):**

I authorize you to speak to the following person(s) regarding my account and/or treatment:

_____	_____
<b>Name</b>	<b>Relationship</b>
_____	_____
<b>Name</b>	<b>Relationship</b>

**Authorization to Release Information:**

I authorize the release of any medical information related to my treatment to my insurance carrier(s), or any other individuals or companies deemed necessary to determine my insurance benefits payable for services or supplies received by Luke Carlson Physical Therapy & Sports Medicine.

**Financial Responsibility:**

Luke Carlson Physical Therapy uses Medical Billing Authority to submit all claims for charges to your insurance provider as a service to you. If your policy requires a referral, please have it with you at your first visit. Failure to obtain and present this at the time of service may result in a reduction and/or loss of your insurance benefits.

**I have read the above policies and agree to them. I authorize Luke Carlson Physical Therapy to furnish information to my physician, insurance company, worker's compensation or attorneys concerning my injury and treatment by any means necessary. I understand that I am financially responsible for the payment of all services that are not paid by my insurance carrier. Should my account be referred for collection, I will be responsible for paying the costs of collection, including any legal fees that may arise from this action.**

\_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient/Responsible Party**

\_\_\_\_\_ **Date:** \_\_\_\_\_  
**Office Manager**