TherapyWorks

Patient Information Form

☐ NEW ☐ RETURNED ☐ GYM MEMBER

Patient Name (Last, First, MI): **Date of Birth** **Age**

Address (Street-City-State-Zip) **Primary Phone** **Secondary Phone**

Employer Name **Occupation** **Social Security Number**

Email Address (for Home Exercise Program or contact with therapist, if desired)

Referring Physician **Date of last Appt.**

Injury or Condition **Date of Injury** **Surgery on affected area? Date:**

☐ **Yes** ☐ **No**

Primary Insurance Name

Secondary Insurance Name

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING THIS YEAR:

☐ Chiropractic Care ☐ Speech ☐ Home Health (discharge date __/__/__) ☐ None of these

☐ Occupational Therapy ☐ Physical Therapy If yes, how many visits each?_____

Was this an automobile accident? ☐ **Yes** ☐ **No**

Have you fallen? Yes / no (circle one) **How many times in the past year?** _____

If you have fallen, what caused your fall(s):

I authorize treatment deemed necessary by FWTW, Inc in accordance with the American Physical Therapy Association guidelines. I authorize payment for medical services directly to FWTW, Inc. FWTW, Inc has my permission to release records to my Insurance company, referring and primary Doctors.

I confirm that the above information is true, and that I am covered by my Medical Insurance, or I will repay FWTW, Inc for Medical Services rendered. This office will bill all insurance. If payment is not received within 60 days from billing, the patient will be responsible. As a courtesy to you, we will verify your insurance benefits, but ultimately this is the patient's responsibility to verify. Thank You.

(SIGNATURE) **(DATE)**

Rev. 10-14-15

Medical Questionnaire

Check the box if you have had any of the following conditions:

- ☐ Diabetes (Type I/II)
- ☐ High Blood Pressure
- ☐ Heart Problems
- ☐ High Cholesterol
- ☐ Shortness of Breath
- ☐ Chest Pain
- ☐ Ankle Swelling
- ☐ Asthma
- ☐ Smoking
- ☐ Other:
- ☐ Dizziness/Fainting
- ☐ Headaches
- ☐ Nausea/Vomiting
- ☐ Stroke
- ☐ Numbness/Tingling
- ☐ Osteoporosis
- ☐ Arthritis:_____
- ☐ Bowel/Bladder Change
- ☐ Kidney Disease
- ☐ Cancer: _____
- ☐ Night Pain
- ☐ Night Sweats
- ☐ Unexplained weight change
- ☐ Pacemaker/Defibrillator
- ☐ Seizures
- ☐ Rheumatic Disease
- ☐ Hepatitis
- ☐ Neuropathy

Allergies: _____

List Your Medications and Supplements

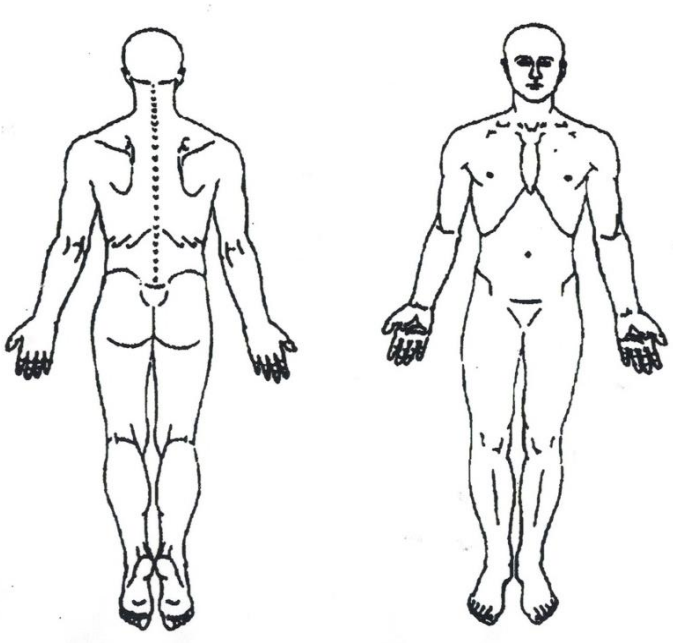
☐ List included in chart

Medication	Purpose

Past surgeries:

Please rate your pain: 0 1 2 3 4 5 6 7 8 9 10

Use the diagram below to indicate the location(s) of your symptoms



Describe your symptoms: _____

When and how did this begin? _____

Imaging for this condition? (x-ray, MRI, etc.)
If so, where:

Are symptoms: worsening **/** improving **/** maintaining

What makes symptoms better? _____

What makes symptoms worse? _____