Robinson Physical Therapy and Health Center, Inc. Confidential Medial History/Evaluation

Name: ____ Date: _____/______/_____ Date of Birth: _____/______/______

Address: ____ Phone: _________________________ SS#: __________________

Cell/Work Phone:___________________________________ Email Address: ____

Referring MD:____ Phone:____________________________

Primary Care Physician: ____________________________ Address: ______________________________ Phone: _________________________

Patient Employer:____ Phone: __________________________

Insurance Company: ____ Claim/ID #:__________________________________ Group #: _________

Policy Holder Name: ____ Policy Holder Date of Birth: _____/______/______

Policy Holder Employer: ____ Policy Holder SS#:_________________________

Secondary Insurance: ____ Subscriber ID#:_______________________ Group #: _______

Policy Holder Name: ____ Policy Holder Date of Birth: _____/______/______

Policy Holder Employer: ____ Policy Holder SS#:_________________________

Occupation: __________________________________ Is this injury work/auto related? _____Yes _____No Date of Injury: _____/_____/_____

Current Symptoms: _____Pain _____Numbness _____Stiffness _____Weakness Condition: _____New _____Acute _____Chronic

List any/all medications you are currently taking: ____

List any surgeries/Date of surgery:____

Have you had any Diagnostic or Rehabilitative Services for this injury? _____MRI _____X-rays Other:_______________________________

Have you seen a Physical Therapist or Chiropractor in the current year? _____Yes _____No Number of Visits:______________________

How did you hear about us?____

Do you have any of the following?

	YES	NO		YES	NO
Asthma, Bronchitis or Emphysema	_____	_____	Emotional/Psychological Problems	_____	_____
Shortness of Breath/Chest Pain	_____	_____	Bowel or Bladder Problems	_____	_____
Coronary Heart Disease	_____	_____	Severe/Frequent Headaches	_____	_____
Do you have a Pacemaker	_____	_____	Vision/Hearing Difficulties	_____	_____
High Blood Pressure	_____	_____	Dizziness or Faintness	_____	_____
Hypotension (Low Blood Pressure)	_____	_____	AIDS	_____	_____
Heart Attack/Surgery	_____	_____	Sleeping Difficulties	_____	_____
Stroke/TIA	_____	_____	Gout	_____	_____
Blood Clot/Emboli	_____	_____	Kidney Problems	_____	_____
Epilepsy/Seizures	_____	_____	Menstrual Problems	_____	_____
Thyroid Trouble/Goiter	_____	_____	Neurological Disorders	_____	_____
Anemia	_____	_____	Skin Disease	_____	_____
Infectious Disease	_____	_____	Tuberculosis	_____	_____
Diabetes	_____	_____	Ulcer	_____	_____
Hypoglycemia (Low Blood Sugar)	_____	_____	Orthotics	_____	_____
Cancer or Chemo/Radiation	_____	_____	Metal Implants	_____	_____
Arthritis/Swollen Joints	_____	_____	Are you pregnant	_____	_____
Osteoporosis	_____	_____	Smoking	_____Daily	_____Weekly
Varicose Veins	_____	_____	Alcohol Consumptions	_____Daily	_____Weekly

Other Medical Conditions:____

____

Are you aware of your Diagnosis? _____Yes _____No Are you aware of your Prognosis? _____Yes _____No

Do you have a living will? _____Yes _____No If no, would you like a copy of one? _____Yes _____No

I hereby agree and give my consent to medial treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any changes that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Robinson Physical Therapy regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Patient/Parent/Guardian Signature: ____ **Date:** ________________________

I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient/Parent/Guardian Signature: ____ **Date:** ________________________