



Physical Therapy & Wellness Center

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### Patient Information Sheet

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

Home Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

I would like to receive our CURE newsletter and other information via E-mail

### Primary Insured

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

### Emergency Contact

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

Authorization to release medical information to this individual:  Yes  No

### Referring Physician

Referring Doctor: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

### Consent of Treatment / Assignment of Benefits

I hereby consent to and authorize all treatment considered medically necessary or advisable by the physician and physical therapist. I understand that the Physical Therapist (PT) or Physical Therapy Assistant (PTA) may provide various portions of my treatment as so advised by the physician. I authorize payment directly to Cure Physical Therapy and hereby agree that I am financially responsible for any services rendered and for charges or supplies not covered by this assignment. I authorize release of my medical information for billing purposes.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature (Parent or Legal Guardian if Patient under 18)

\_\_\_\_\_  
Date



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## Physical Therapy Questionnaire / Evaluation

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Problem Area: \_\_\_\_\_

Please describe briefly the history of your current illness or injury: \_\_\_\_\_

Are you or is there a possibility you are pregnant? YES NO  
Do you smoke? YES NO If yes, how much do you smoke per day? \_\_\_\_\_

Please list your current medications or attach list:

Please list past surgical history with an approximate date:

**Past Medical History:** Please circle each condition that you have been told you have /think you have:

Cancer	High Blood Pressure	Osteoporosis
Allergies/ Asthma	Diabetes	Heart Disease
Osteoarthritis	Lung Disease	Kidney Disease
Angina/Chest Pain	Rheumatoid Arthritis	Liver Disease
Stroke	Fibromyalgia	Pacemaker
Metal Implants	Depression	Claustrophobia

**Are you currently suffering from any of the following** (circle) Yes No

Unexplained weight loss	Difficulty swallowing	Changes in appetite
Changes in bowel or bladder function	Nausea / Vomiting	Fever/ Chills/ Sweats

Approximately when did your current complaints start: \_\_\_\_\_

Have your symptoms been: Getting worse Getting better Staying the same

What treatments have you had for this condition: \_\_\_\_\_

What makes your symptoms better: \_\_\_\_\_

What makes your symptoms worse: \_\_\_\_\_

Have you had an X-ray / MRI / other imaging? Yes No

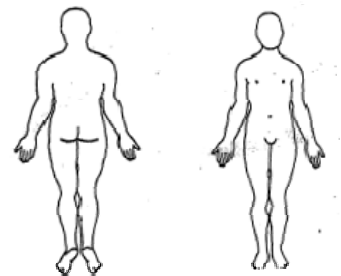
Please circle what has been your AVERAGE pain level:

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

Other Comments: \_\_\_\_\_

**Body Chart**

Please Mark Your Areas of Pain





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## Acknowledgement of Notification of Patient Privacy Rights

I have been issued a copy of Cure Physical Therapy's notice of patient privacy practices delineating how my information, under the state of federal rules and regulations, will disclose my personal health information.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Sign Name (If patient under 18 please have legal guardian or parent sign)      Date

## Appointment Policy

I understand my physician has prescribed physical therapy for my condition and regular attendance/participation is needed to maximize my progress. I, to the best of my ability, will attempt to give **24 hour notice** prior to any cancellation. Furthermore, if I cancel/no show 3 appointments all remaining appointments may be cancelled and future visits will be scheduled individually. I may also possibly be discharged from physical therapy care due to non-compliance. If I am more than 10 minutes late I may have an abbreviated treatment and possibly have the appointment cancelled and re-scheduled.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Sign Name (If patient under 18 please have legal guardian or parent sign)      Date