Confidential Medical History

Patient Name:________________________________ Date of Birth:____/____/____ Marital Status: Single Married Divorced Other

Male Female Home Phone: ________________________ Cell:_________________________

Email:____

Address: ____ City: ____________________ State: _____ Zip Code: ______________

Patient's Employer:__________________________________ Occupation:__________________________ Work Phone:______________

Referring Doctor:____ Is this injury? Work Related Auto Accident

Emergency Contact Name:______________________________ Phone:_______________ Cell:______________ Work:_______________

CHIEF COMPLAINT:____

DATE OF INJURY:______________ **DATE OF SURGERY:**_______________ **RETURN TO DR. DATE:**_______________

Have you had any home health services this year?__________ **Have you had any other physical therapy services this year?**___________

List any surgeries:____

Have you had any Diagnostic or Rehabilitative Services for this Injury? MRI Xrays Other:___________________________________

Do you have any of the following?

	YES	NO		YES	NO
Asthma, Bronchitis or Emphysema	____	____	Infectious Disease	____	____
Shortness of Breath/Chest Pain	____	____	Diabetes	____	____
Coronary Heart Disease	____	____	Cancer or Chemo/Radiation	____	____
Do you have a Pacemaker	____	____	Gout	____	____
High Blood Pressure	____	____	Thyroid Trouble/Goiter	____	____
Heart Attack/Surgery	____	____	Epilepsy/Seizures	____	____
Stroke/TIA	____	____			
Blood Clot/Emboli	____	____	Are you pregnant?	____	____

Other Medical Conditions____

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I hereby agree and give my consent to medical 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 charges 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 Gina V 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:_________________________

How did you find out about Gina V Physical Therapy?____

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