Therapy and Sports Center of St. Petersburg
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THERAPY AND SPORTS CENTER
PHYSICAL THERAPY

10/02/2019

Patient Information:

Patient Name:	**DOB:**
Address:	**Apt #:**
City:	**State:**
Zip:	
SSN:	
Cell Phone:	**Work Phone:**
Home Phone:	**E-Mail Address:**

Treatment Information:

Primary Complaint:	**Date of Onset:**_____ **Date of Surgery:**_____
Referring MD:	**MD Phone Number:**
Primary Care Doctor:	**PCP Phone Number:**

Emergency Contact:

Name:	
Phone:	**Relationship:**

Employment Information:

Employer Name:	**Phone Number:**
Job Title:	

Job Status (circle all applicable): Full-Time Part-Time Full-Duty Modified-Duty Off-Work Retired

Primary Insurance:

Insurance Name:	
ID #:	
Policyholder Name:	
Relation to Policyholder:	
Insurance Benefits:	**Annual Benefits:**
Coinsurance	**Authorizations:**

Additional Insurance Information:

Secondary Insurance Name:	Policyholder:
ID#:	Policyholder DOB:
Attorney Name:	Phone Number:
Adjustor Name:	Phone Number:

Liability Injury

Are you receiving care for injuries sustained in a Motor Vehicle Accident? Yes No
Are you receiving care for injuries from a Workman's Compensation Accident? Yes No
If yes, what state did the accident occur in? _____
What was the date of your accident? ____/____/_____

Appointment Reminders

Would you like to receive appointment reminders via e-mail or text message? Yes No
Preferred method (circle one) : E-mail Text
If text, please provide your cell-phone **service provider:**
☐ Boost ☐ Cricket ☐ Sprint ☐ AT&T ☐ T-Mobile ☐ Verizon ☐
Other:_____

Have you recently had Home health? Yes No
If yes, when were you discharged?_____
Have you had Physical Therapy treatment elsewhere, this year? Yes No
If yes, where, and how many visits?_____

Patient or Guardian Agreement:

☐ I authorize the release of my information as requested by my insurance plan for payment.
☐ I give my consent for treatment rendered by Therapy and Sports Center.
☐ I understand that I have been given a description of my insurance benefits. I understand my insurance contract is the final basis for benefit determination and I am responsible for any amount not paid by my insurance company.
☐ I will strive to keep and arrive on time to my appointments and I understand multiple missed appointments may result in a status of non-compliance.

Signature of Patient or Guardian: _____ Date _____

Notice of Privacy Practices:

☐ I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices.

Signature of Patient or Guardian: _____ Date _____

THERAPY & SPORTS CENTER – Patient Medical History Form

Name: _____ D.O.B: _____ Date: _____

Referring Dr: _____ /#: _____ Primary Care Dr: _____ /#: _____

SOCIAL HISTORY: What is your occupation: _____ □ Full Time □ Part Time □ Unemployed □ Self Employed □ Retired □ Homemaker □ Student □ Other: _____

Do you live alone: Yes / No List any physical barriers in your residence that cause you difficulties: _____

Have you had a fall in the Past 12 months?: YES / NO If yes, How many times have you fallen?: _____

Have any of the falls resulted in an injury?: YES / NO If yes, what type of injury did you sustain?: _____

IS YOUR CONDITION RELATED TO AN AUTOMOBILE, WORK RELATED OR SLIP & FALL INJURY?: YES / NO

If yes, when was the date of injury?: _____ In what State did the injury occur?: _____

Claim Adjuster's Name: _____ Phone#: _____ Fax#: _____

Do you have an attorney?: Yes / No Attorney Name/Firm: _____ Phone #: _____

Have you had surgery for this injury? YES / NO Date of surgery: ___/___/___ Type of surgery: _____

MEDICAL HISTORY: Height: _____ Weight: _____ Do you/have you ever Smoked?: Yes / No

How would you rate your overall health: Excellent Good Fair Poor

Please list any allergies: _____

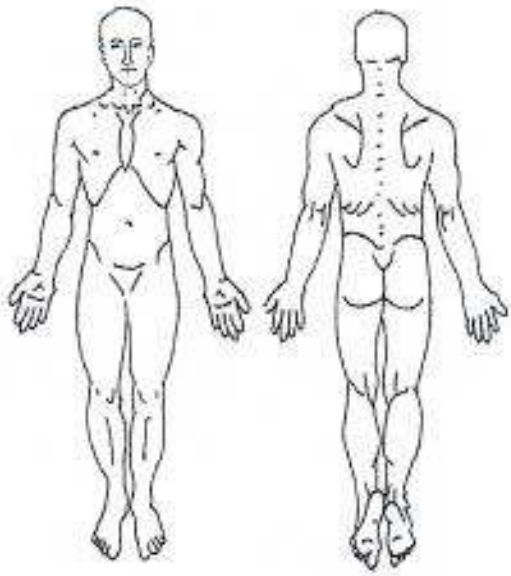
*Please list current Medications (*Medicare Recipients, Document on the Current Medications Form on the next page)

Do you now have or have you ever had ANY of the following?

	YES	NO
Asthma, bronchitis or emphysema	____	____
Shortness of breath/chest/pain	____	____
Coronary heart disease/angina	____	____
Heart attack or heart surgery	____	____
Do you have a pacemaker?	____	____
High blood pressure	____	____
Stroke/TIA Date: ___/___/___	____	____
Blood clot/emboli	____	____
Epilepsy/seizures	____	____
Anemia	____	____
Infectious diseases	____	____
Diabetes	____	____
Cancer or chemotherapy	____	____
Arthritis/swollen joints	____	____
Osteoporosis	____	____
Severe/frequent headaches	____	____
Vision/hearing difficulties	____	____
Dizziness/fainting	____	____
Weight loss/energy loss	____	____
Hernia	____	____
Sleeping prob/difficulties	____	____
Any joint/metal implants	____	____
Joint replacements	____	____
Shoulder injury/surgery	____	____
Elbow/hand injury/surgery	____	____
Neck/back injury/surgery	____	____
Knee injury/surgery	____	____
Leg/ankle injury/surgery	____	____
Are you pregnant?	____	____

On the body diagram below SHADE IN THE AREA(s) you are having pain, tingling or numbness with this episode

INDICATE: X for pain, = for numbness, * for tingling, # for burning



On a scale of 0 (no pain) to 10 (severe/disabling pain), rate your pain at at its BEST: _____ / WORST: _____

On a scale of 0% (worst) to 100% (best) what percentage of normal function are you able to perform? (This includes work performance, home activity, sports, socially with friends: _____

CURRENT EPISODE

When did your symptoms this episode start: Date: _____ Describe your symptoms: _____

How often do you experience your symptoms?: Constantly: _____ Frequently: _____ Occasionally: _____ Rarely: _____

How much have your symptoms interfered with your daily activities?:

Never: _____ A little bit: _____ Moderately: _____ Quite a bit: _____ Extremely: _____

Have you had similar symptoms in the past?: Yes: _____ / No: _____

Who did you see for your symptoms: No One: ___ Medical Doctor: ___ Chiropractor: ___ Physical Therapist: ___ Other: _____

What treatment(s) did you receive?: X-Rays: ___ MRI: ___ CT Scan: ___ Surgery: ___ Other: _____

Patient Signature: _____ **Date:** _____

(MEDICARE PATIENTS)