

LAST NAME: _____ FIRST: _____ D.O.B. _____ AGE: _____
 DIAGNOSIS: _____
 PHYSICIAN: _____

CIRCLE YES OR NO. IF YES, PLEASE EXPLAIN IN THE SPACE PROVIDED.

- YES NO Are you pregnant or planning on becoming pregnant? _____
- YES NO Currently being treated elsewhere for this or another injury? _____
- YES NO Have you been seen elsewhere for this injury? _____
- YES NO History of high or low blood pressure? _____
- YES NO History of heart disease? Heart attacks/M.I.? _____
- YES NO Presently have a pace maker? _____
- YES NO Previous strokes/CVA? _____
- YES NO History of any illness (i.e., diabetes, asthma, seizures, etc.)? _____
- YES NO Current/history of any skin diseases? _____
- YES NO Any emotional/psychological disturbances? _____
- YES NO Please list current medications. _____
- YES NO Any allergies? _____
- YES NO Respiratory difficulties? _____
- YES NO Any bowel or bladder disturbances? _____
- YES NO Any unusual bleeding? _____
- YES NO Any unusual reactions to heat or cold? _____
- YES NO Special diet restriction? _____
- YES NO Any present visual problems? _____
- YES NO Any present hearing problems (including hearing aids)? _____
- YES NO Do you smoke? How many packs a day? _____
- YES NO Is visit accident related? Work? Auto? Other? _____
- YES NO History of fractures? Dislocations? _____
- YES NO Arthritis or joint problems? _____
- YES NO Sensory disturbances? _____
- YES NO Any current movement/tasks unable to perform? _____
- YES NO Do you require any special help at home? _____
- YES NO Previous hospitalizations/surgeries/cancer? _____
- YES NO Please list recreational activities (including prior to visit). _____
- YES NO Do you have any other form of health insurance coverage? If yes, please print the name of the insurance policy: _____

I, THE UNDERSIGNED, DO HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION, INCLUDING REPORTS OF DIAGNOSIS, TREATMENT PROGNOSIS, RECOMMENDATION, BENEFITS PAYABLE, AS WELL AS OTHER DATA PERTINENT TO MY TREATMENT TO THE PHYSICIAN WHO REFERRED ME FOR THERAPY, AND/OR TO ANY ORGANIZATION OR PERSON RESPONSIBLE FOR THE PAYMENT OF MY ACCOUNT. A COPY OF THIS CAN BE CONSIDERED AS AN ORIGINAL FOR INSURANCE PURPOSES AND VALID AS AN ORIGINAL.

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give consent for Physical Therapy Services to furnish medical care and treatment considered necessary and proper in evaluating and treating my physical condition. I, the undersigned, will allow Physical Therapy Services to receive/send medical records pertaining to my condition via fax machine and/or mail. **I HAVE READ AND UNDERSTAND THE ABOVE POLICIES.**

X _____ X _____
 Patient or guardian's signature Date Therapist's signature Date