ADVANCED SPINE PHYSICAL THERAPY
PERSONAL INFORMATION

Date_________ Full Name______________________________________
Address______________________________________ City______________State_____Zip______
Phone: Home____________ Work___________ Cell____________Email_____________________
Gender: M/ F Date of Birth_____________ Social Security #______________Marital Status___
Employer_________________________ Occupation________________ Work Status___________
Insurance Plan__________________________ Policy/Claim # ______________________
MVA____ WC___ Other Accident ________________________Date of Injury _________
Name of Primary Insured __________________________Relationship________ Phone #________
Address______________________________________ City______________State_____Zip______
Emergency Contact _____________________________ Phone # __________________
Referring Physician _____________________ Primary Care Physician ______________________

MEDICAL HISTORY

How long have you had this problem? _____________How much pain do you have? 0_______10.
Have you had surgery for this problem? Yes___ Date _____ No___
Type of surgery ___________________________ Area of surgery ___________________
Have you received Physical/Occupational Therapy for this problem before?____
Current medications & Dosages ____
Allergies ________________________________ Pregnant Yes ___ No ____

Do you have, or have you ever had any of the following conditions? (Please check condition)

□ Lung Disease	□ Diabetes	□ Dizziness/Fainting
□ Joint Replacement	□ Heart Disease	□ Cancer
□ Weakness	□ Pacemaker	□ Pins/metal implants
□ Osteoporosis	□ Stroke/TIA	□ Loss of bladder control
□ Hypertension	□ Blood Clots	□ Loss of bowel control
□ AIDS/HIV	□ Hepatitis	□ TB

List any additional information that would assist us with your care:
____
What are your goals for Physical/OccupationalTherapy? ______________________________
____
I hereby consent to such treatment procedures and patient care which, in the judgement of my therapist and/or physician, may be considered necessary or advisable while a patient at
ADVANCED SPINE PHYSICAL THERAPY

_________________________________ ___________________
Signature of patient or guardian Date