

**PATIENT INFORMATION Date**: / /

**Name**: **Soc Sec #**: - -

Last Name First Name Initial

**Address**:  **City/State/Zip**:

**Home Phone**: ( ) **Work Phone**: ( ) **Cell Phone**: ( )

**E-Mail Address**: **Cell Phone Provider**:

Would you like to receive appointment reminders by:  **Email**   **Text Message**

**Sex**: M F **Birthdate**: / / **Age**: **Single Married Widowed Separated Divorced**

**Patient Employer**: **Occupation**:

**Employer Address**: **City/State/Zip**:

**Spouse/Guardian Name**: **Spouse/Guardian Birthdate**: / /

**Spouse/Guardian Employer**: **Spouse Soc Sec** #: - -

***In case of an emergency, please notify***:  **Phone**: ( )

Referring Physician: Primary Physician:

Injury Date (or approximate date):

*Who may we thank for this referral?*

***(Please see medical history on next page)***

**Assignment, Release and Consent:**

I, the undersigned, certify that I (or my dependent) has insurance coverage with and assign directly to **Sportcare Physical Therapy/Curnyn Physical Therapy** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize **Sportcare Physical Therapy/Curnyn Physical Therapy** to release all information necessary and use this signature to secure the payment of benefits. I further certify that the above patient information and history is accurate and complete. I hereby authorize and give my consent for treatment of the condition for which my physician referred me.

Responsible Party Signature Relationship Date

**Patient Name:**

Pain level 0-10 (0 = none, 10 = call 911): Location of pain on body:

Where did this happen?

What happened?

Pain relieved/better with: Pain worse with:

Have you received physical, occupational, speech, chiropractic therapy or home health services in the past year? **Yes No**

If for this injury, what was the result?

Are you currently receiving any Home Health services? **Y N**

Presently Working: **Y N** Hand Dominance: **R L**

Current job status/duties: Normal Modified duty Off work Unemployed

**Medical History – Please indicate if you have had any of the following and dates if applicable:**

Heart Problems **Y N** High Blood Pressure **Y N**

Diabetes **Y N** Allergies **Y N**

Lung Problems **Y N** Back/Neck Problems **Y N**

Asthma **Y N** Shortness of Breath **Y N**

Dizziness **Y N** Chest Pain **Y N**

Stroke **Y N** Traumatic Head Injury **Y N**

Blood in Urine **Y N** Hernia **Y N**

Cancer **Y N** Arthritis **Y N**

Seizures **Y N** Osteoporosis **Y N**

Pace Maker **Y N** Other:

Height: Weight: Smoker: **Y N**

Current Medications:

Brief medical/surgical history (including date, if applicable):