Name: ______________________________ **DOB:** ____/____/____
Last First Middle

SSN: ____/____/____ **Sex:** M F (Check One) **Marital Status:** S M D W (Check One)

Address: ______________________________
Street City State Zip

Cell Phone: ____-____-____ Can leave confidential voicemail at this number Y N **Home Phone:** ____-____-____ Can leave confidential voicemail at this number Y N

Email: ______________________________

Occupation: ______________________________ **Referring MD:** ______________________________

Leisure Activities: ______________________________

IF PATIENT IS A MINOR

Parent/Guardian name: ______________________________

Parent/Guardian DOB: ____/____/____ **Parent/Guardian Phone:** ____-____-____

Emergency Contact Name/Phone #: ______________________________ ____-____-____

Please explain WHEN, WHERE AND HOW your injury occurred: ______________________________

____

____

Insurance Information

Primary Insurance Name: ______________________________

Policy #: ______________________________ **Group #:** ______________________________

Insured Name/DOB: ______________________________ ____/____/____

Secondary Insurance Name: ______________________________

Policy #: ______________________________ **Group #:** ______________________________

Insured Name/DOB: ______________________________ ____/____/____

Attorney

Attorney Name/Phone: ______________________________ ____/____/____

Address: ______________________________
Street City State Zip

Date Of Accident: ____/____/____

Worker's Comp

Claim #: ______________________________ **State/Date of Injury:** ______ (State) ____/____/____ (Date of Injury)

Adjuster Name/Phone #: ______________________________ ____-____-____

Employer Name: ______________________________

Employer Address: ______________________________
Street City State Zip

Auto Insurance

Auto Insurance Name: ______________________________

Policy Holder Name/DOB: ______________________________ ____/____/____

Claim #: ______________________________ **State/Date of Injury:** ______ (State) ____/____/____ (Date of Injury)

Please provide a copy of your Drivers License/ID and Insurance card(s)/Claim information

To ensure you receive a complete and thorough evaluation, please provide us with the important information requested on the following forms. If you do not understand a question, leave it blank and a staff member will assist you. Thank you!

TURN OVER

Please check any of the following whose care you are currently under:

Medical Doctor (M.D.): Osteopath: Dentist: Psychiatrist/Psychologist: Chiropractor:

If you have seen any of the above during the past 3 months, please explain the reason:___________________________

____

Allergies:

Please list any allergies we should know about:____

____

Are you latex sensitive: Yes No (check one)

Past Medical History:

Have you ever been diagnosed or told you have any of the following: (Please check all that apply)

Anemia	Hepatitis
Arthritis	High Blood Pressure
Asthma	Kidney Disease
Circulation Problems	Mental Illness
Diabetes	Multiple Sclerosis
Emphysema/Bronchitis/COPD	Osteoporosis
Epilepsy	Rheumatoid Arthritis
Fibromyalgia	Stroke
Headaches	Thyroid Problems
Heart Disease	Tuberculosis

Cancer? If yes, describe what kind:____

I currently have: (Please check all that apply)

Bowel & Bladder Changes	Nausea/Vomiting
Dizziness/Lightheadedness	Numbness/Tingling
Falls	Poor Balance
Fatigue	Weakness
Fever/Chills/Sweats	Weight Loss/Weight Gain

In the past month have you been feeling down, depressed or hopeless? Y N (check one)

Do you have any history of chemical dependency or alcoholism? Y N (check one)

For Women: Are you currently pregnant or do you think you might be pregnant? Y N (check one)

Diagnostic Testing you have had: (Please check all that apply)

MRI XRAY CT Scan EMG

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the hospitalization:

Date:	Reason for Hospitalization:
____________	____
____________	____
____________	____

Please list any PRESCRIPTION medication(s) you are currently taking (INCLUDING pills, injections, lotions and/or skin patches): ____

____

What are your goals for Physical Therapy:____

____

TURN TO NEXT PAGE

I certify, to the best of my knowledge, that all of the information on these forms are correct. I authorize the release my medical records concerning the health care, advice and treatment provided to the patient (myself or dependent) for insurance, billing and/or auto and attorney related purposes.

I also authorize Physical Therapy Services of West Louisiana (PTSOWLA) to bill my insurance company, electronically if applicable, on my behalf. I acknowledge, and understand, that I am responsible for all charges for the therapy I receive. Although I have requested PTSOWLA to bill my insurance company on my behalf, I understand that it is my responsibility to make certain that the bill is paid in a reasonable amount of time.

I realize that I am responsible for any applicable co-payments, coinsurance and/or deductibles that I have with my insurance company.

If my account becomes a self pay account, for ANY reason, I am responsible for setting up a payment plan with PTSOWLA that will consist of payments of at least 5% of my bill once a month until the bill has been paid in full.

Additionally, I acknowledge that I have received a copy of the NOTICE OF PRIVACY PRACTICES of Physical Therapy of West Louisiana.

_______________________________ Signature (If minor, Parent/Guardian)

_______________________________ Date