BUCKS PHYSICAL THERAPY AND SPORTS REHABILITATION

PATIENT INFORMATION FORM

LAST NAME: _____ FIRST NAME:_____

ADDRESS:_____
STREET CITY STATE ZIP

HOME PHONE: _____ CELL PHONE: _____ EMAIL ADDRESS: _____

DATE OF BIRTH: _____/_____/_____ SS#: _____-_____-_____ MALE: _____ FEMALE: _____

WHERE INJURY OCCURRED: WORK _____ HOME _____ AUTO _____ OTHER _____

EMPLOYER: _____ DATE OF INJURY: _____/_____/_____ REFERRING MD: _____

ACCIDENT INFORMATION

CLAIM NUMBER: _____ ADJUSTER NAME: _____

INSURANCE NAME: _____ INSURANCE PHONE NUMBER: _____

CLAIM MAILING ADDRESS: _____
STREET CITY STATE ZIP

PRIMARY HEALTH INSURANCE

INSURANCE NAME: _____ ID #: _____

GROUP #: _____ SUBSCRIBER NAME: _____

SUBSCRIBER D.O.B. : _____/_____/_____ RELATIONSHIP TO SUBSCRIBER: _____

SUBSCRIBER ADDRESS (if different): _____
STREET CITY STATE ZIP

SECONDARY HEALTH INSURANCE

INSURANCE NAME: _____ ID #: _____

GROUP #: _____ SUBSCRIBER NAME: _____

SUBSCRIBER D.O.B. : _____/_____/_____ RELATIONSHIP TO SUBSCRIBER: _____

SUBSCRIBER ADDRESS (if different): _____
STREET CITY STATE ZIP

ASSIGNMENT OF BENEFITS/SIGNATURE ON FILE: I authorize payment of medical benefits to BUCKS PHYSICAL THERAPY AND SPORTS REHABILITATION for services rendered to me while under their care. I also acknowledge responsibility for payment of all medical fees regardless of any insurance I may have. If for any reason me account should become delinquent, I agree to pay for all collection and legal fees.

AUTHORIZATION TO RELEASE INFORMATION: I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES and understand my rights under the federal privacy standards. Furthermore, I authorize the release of any medical information necessary to evaluation and treating my medical condition, obtaining payment from insurance companies, public health reporting and if requested by certain law enforcement agencies

SIGNATURE: _____ DATE: _____

MEDICAL HISTORY

PLEASE ANSWER ALL QUESTIONS, COMMENTS ON ALL POSITIVE ANSWERS IN THE SPACE PROVIDED INCLUDING ALL APPROPRIATE INFORMATION AND YEAR OF OCCURRENCE.

Please describe, in your own words, the symptoms or discomfort that prompted you to seek physical therapy:

_____

_____

During the past year, have you had any physical therapy or chiropractic treatment for any conditions (current or prior):

_____

PAST ILLNESSES OR MEDICAL PROBLEMS

HAVE YOU EVER HAD:	YES	NO	COMMENTS
Addiction to Drugs / Alcohol			
Allergies / Skin Problems			
Asthma / Bronchitis			
Arthritis			
Appendicitis			
Anemia, Leukemia			
Back Injury / Concussion			
Cancer			
Diabetes			
Eye / Ear Problems			
Epilepsy / Seizures			
Fainting Spells / Dizziness			
Fractures / Dislocations			
Frequent Colds			
Heart Trouble			
Heat Exhaustion			
Hepatitis			
Hernia			
High / Low Blood Pressure			
Kidney / Bladder Problems			
Mental Illness / Nervous Breakdown			
Mononucleosis			
Neck Injury			
Osteoporosis / Osteopenia			
Ulcer / Stomach Trouble			
Family history of high blood pressure?			
Are you pregnant?			
Ever had surgery? If so, what kind?			
Ever been hospitalized? If yes, why?			
Do you have any illness/injury not mentioned above? Describe.			

AUTHORIZATION TO RELEASE INFORMATION: I acknowledge receipt of the privacy practices and understand my rights under the federal privacy standards. Furthermore, I authorize release of any medical information necessary to treating my medical condition, obtaining payment from insurance companies, public health reporting and if requested by law enforcement agencies.

SIGNATURE: _____ DATE: _____

PAIN DISABILITY INDEX

Please circle your current pain level for the following activities:

Family/Home Responsibilities

10 9 8 7 6 5 4 3 2 1 0

Total Disability Severe Moderate Mild No disability

Recreation

10 9 8 7 6 5 4 3 2 1 0

Total Disability Severe Moderate Mild No disability

Social Activity

10 9 8 7 6 5 4 3 2 1 0

Total Disability Severe Moderate Mild No disability

Occupation

10 9 8 7 6 5 4 3 2 1 0

Total Disability Severe Moderate Mild No disability

Sexual Behavior

10 9 8 7 6 5 4 3 2 1 0

Total Disability Severe Moderate Mild No disability

Self-Care

10 9 8 7 6 5 4 3 2 1 0

Total Disability Severe Moderate Mild No disability

Life-Support Activity

10 9 8 7 6 5 4 3 2 1 0

Total Disability Severe Moderate Mild No disability

Total: _____ Height:_____ Weight: _____