

Pt # _____ Valdosta Physical Therapy, Inc. (229)247-5225

(Please Print...Fill out all items below and sign)

Date: _____

Patient: _____

Responsible Party (If a minor): _____
Last First M.I. Relationship to patient

Street Address: _____ Cell #: _____

City: _____ State: _____ Zip: _____ Home Phone: _____ Sex: M F

Chief Complaint: _____ **Date of onset:** _____

Referring Doctor: _____ **Date of follow-up appt. with MD:** _____

Are you currently having home health: Yes No

Date of birth: _____ Age: _____ Single: Married Widowed: Separated: Divorced:

Patient Social Security #: _____-_____-_____ Spouse Social Security #: _____-_____-_____

Patient Employed By: _____

Business Address: _____ City, State, Zip: _____

Occupation: _____ Phone #: _____

Spouse/Parent: _____ D.O.B.: _____ Employer _____

Business Address: _____ City, State, Zip: _____

Occupation: _____ Phone #: _____

Medicare # _____ **D.O.B.:** _____

Name of Secondary Insurance (if any): _____

Contract #: _____ Group #: _____ DOB Insured: _____

Assignment of Insurance Benefits

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Valdosta Physical Therapy, Inc. for any services furnished to me by that therapist/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the Hcfa-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, assigned cases, the therapist/supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is **responsible only for the deductible, coinsurance, and noncovered services**. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

(Authorized signature of Subscriber)

(Date)

MEDICAL HISTORY

Survey Date: _____

Last Name: _____ First Name: _____

Reason for Referral: _____

Current Condition

Height: ____ FT. ____ IN.

Weight: ____ LBS.

Pregnant? ____ (Y/N)

Currently on Medication? ____ (Y/N)

List Medications: _____

Do you drink alcoholic beverages? ____ (Y/N)

Per Day: ____ Per Week: ____

List Allergies: _____

Describe your general health: (choose one)

____ Excellent ____ Good ____ Fair ____ Poor

Do you use any assistive devices? ____ (Y/N) Cardiovascular Fitness: (Choose One)

List Devices: _____ Aerobic Activity 3-5 days week

Do You Smoke Cigarettes? ____ (Y/N) Occasional Recreation activities at

Packs Per Day ____ least 4 times a month

____ Sedentary Life-style

HISTORY

Have you ever had any of the following? (Check all that apply)

- | | | | |
|-------------------------------------|---|---|------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Headaches | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shortness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> of Breath |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Low Blood Press. | <input type="checkbox"/> Stoke |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Mctal Implants | <input type="checkbox"/> Swollen |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Ankles |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hernia. | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Other |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Press. | <input type="checkbox"/> Rheumatoid arthritis | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> HIV | <input type="checkbox"/> Tuberculosis | List: _____ |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Seizures | |

List surgeries with date: _____

OBJECTIVES:

Primary reasons for attending therapy: (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Activity Reduction |
| <input type="checkbox"/> Limited Motion | <input type="checkbox"/> Loss of Independence |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Unable to Work |
| <input type="checkbox"/> Injury | <input type="checkbox"/> Unable to do Household Tasks |
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Unable to Play Sports or Recreations |

What are your personal goals for therapy: (choose 4 that are most important)

- | | |
|---|--|
| <input type="checkbox"/> Decrease Pain | <input type="checkbox"/> Regain Mobility/Flexibility |
| <input type="checkbox"/> Learn Self-Care Techniques | <input type="checkbox"/> Increase Strength |
| <input type="checkbox"/> Resume/Improve Household Chores | <input type="checkbox"/> Increase Sitting tolerance |
| <input type="checkbox"/> Resume/Improve Gardening | <input type="checkbox"/> Increase Walking Distance/Speed |
| <input type="checkbox"/> Return to Work Activities | <input type="checkbox"/> Improve Posture |
| <input type="checkbox"/> Return to Sports | <input type="checkbox"/> Improve Sleep |
| <input type="checkbox"/> Improve Self-Care (dressing, hair) | <input type="checkbox"/> Improve Body Mechanics |