

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

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

Date: \_\_\_\_\_

Patient: \_\_\_\_\_  
Last First M.I.

Responsible Party (If a minor): \_\_\_\_\_ 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: \_\_\_\_\_

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 #: \_\_\_\_\_

Do you have medical insurance?    NO    YES

Name of primary insurance: \_\_\_\_\_

Contract #: \_\_\_\_\_ Group #: \_\_\_\_\_ DOB Insured: \_\_\_\_\_

Name of Secondary Insurance (if any): \_\_\_\_\_

Contract #: \_\_\_\_\_ Group #: \_\_\_\_\_ DOB Insured: \_\_\_\_\_

**Assignment of Insurance Benefits**

The undersigned hereby authorized the release of any information relating to all claims for benefits on behalf of myself and/or dependants. I further expressly agree and acknowledge that my signature on this document authorized my therapist to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependants, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_ to pay and hereby assign directly to Valdosta Physical Therapy, Inc. all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand that I am financially responsible for all charges incurred. I further acknowledge that insurance benefits, when received by and paid to Valdosta Physical Therapy, Inc. will be credited to my account with the above assignment.

\_\_\_\_\_  
(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)

\_\_\_\_ Anemia                      \_\_\_\_ Headaches                      \_\_\_\_ Kidney Problems                      \_\_\_\_ Shortness

\_\_\_\_ Asthma                      \_\_\_\_ Heart Attack                      \_\_\_\_ Low Back Pain                      of Breath

\_\_\_\_ Cancer                      \_\_\_\_ Heart Disease                      \_\_\_\_ Low Blood Press.                      \_\_\_\_ Stoke

\_\_\_\_ Chest Pain                      \_\_\_\_ Heart Palpitations                      \_\_\_\_ Metal Implants                      \_\_\_\_ Swollen

\_\_\_\_ Diabetes                      \_\_\_\_ Hepatitis                      \_\_\_\_ Osteoarthritis                      \_\_\_\_ Ankles

\_\_\_\_ Dizziness                      \_\_\_\_ Hernia                      \_\_\_\_ Pacemaker                      \_\_\_\_ Other

\_\_\_\_ Emphysema                      \_\_\_\_ High Blood Press.                      \_\_\_\_ Rheumatoid arthritis

\_\_\_\_ Fainting                      \_\_\_\_ HIV                      \_\_\_\_ Tuberculosis                      List: \_\_\_\_\_

\_\_\_\_ Fractures                      \_\_\_\_ Insomnia                      \_\_\_\_ Seizures

List surgeries with date: \_\_\_\_\_

**OBJECTIVES:**

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

\_\_\_\_ Pain                      \_\_\_\_ Activity Reduction

\_\_\_\_ Limited Motion                      \_\_\_\_ Loss of Independence

\_\_\_\_ Weakness                      \_\_\_\_ Unable to Work

\_\_\_\_ Injury                      \_\_\_\_ Unable to do Household Tasks

\_\_\_\_ Surgery                      \_\_\_\_ Unable to Play Sports or Recreations

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

\_\_\_\_ Decrease Pain                      \_\_\_\_ Regain Mobility/Flexibility

\_\_\_\_ Learn Self-Care Techniques                      \_\_\_\_ Increase Strength

\_\_\_\_ Resume/Improve Household Chores                      \_\_\_\_ Increase Sitting tolerance

\_\_\_\_ Resume/Improve Gardening                      \_\_\_\_ Increase Walking Distance/Speed

\_\_\_\_ Return to Work Activities                      \_\_\_\_ Improve Posture

\_\_\_\_ Return to Sports                      \_\_\_\_ Improve Sleep

\_\_\_\_ Improve Self-Care (dressing, hair)                      \_\_\_\_ Improve Body Mechanics



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## Valdosta Physical Therapy, Inc.

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### AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Valdosta Physical Therapy, Inc. to release the

records listed below on, \_\_\_\_\_ to  
(Patient's Name)

\_\_\_\_\_. It is understood that  
the party to whom this information is released will not release it to a  
third party. These records are needed for the following reasons...

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Records to be released: \_\_\_\_\_

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I understand and agree to the above statement:

\_\_\_\_\_  
Patient or Legal Guardian

\_\_\_\_\_  
Date