Therapist Signature:_____ (DOUBLE CHECK HOME HEALTH CARE!)

DYNATEST, INC.

Medical History Form

Patient Name:_____ **Age:**_____
Height:_____ **Weight:**_____

Accident Information: **Date of Accident:**_____/_____/_____
Are you here today due to an accident? Yes/No Was the accident work related? Yes/No
Was the accident a result of a Motor Vehicle Accident (MVA)? Yes/No
Give a brief description of how the accident occurred:_____
_____
_____

What are we treating you for today? (please indicate body part)_____
What is your pain level? 1 2 3 4 5 6 7 8 9 10

What goals would you like to accomplish with your therapy treatment?_____
_____

Please list all medication: (please see attached list: __yes __no)
_____ _____ _____
_____ _____ _____

Past Medical History – Do you have a history of…(mark all that apply)

__High Blood Pressure	__Cancer	__Muscle Weakness
__Heart Condition	__Osteoarthritis	__Muscular Sclerosis
__Stroke	__Diabetes	__Internal Fixation Device
__Pacemaker	__Fibromyalgia	__Artificial Joint_____
__Seizure	__Currently Pregnant	(please indicate which joint)

Do you smoke or are you a former smoker? ___daily ___occasionally ___quit ___no

Previous surgeries: __yes __no (if yes, please specify the procedure and when it took place)
_____

Have you had Home Health Care? __yes __no
If yes, please indicate the date of discharge: _____/_____/_____**this would include any type of home visit care (i.e. nurse visits, wellness checks, home therapy, etc.)
The answer is important as Medicare will not pay for physical therapy if the patient is currently under home health care. If you answer no and Medicare denies your claim or recoups your claim payment due to being under home health care, you will be held financially responsible for the claims. If you answer yes, it is your responsibility to be discharged completely prior to evaluation. If you would like our staff to assist with this process, please let us know verbally. By continuing with this evaluation, you are accepting responsibility for services deemed covered by Home Health Care. If this is a concern, evaluations can be rescheduled.
Current activity/exercise level:
__0 days/week __1-2 days/week __3-5 days/week __6-7 days/week
Type of activity/exercise:_____

****The above information is complete, correct, and true to the best of my knowledge****
Patient/Guardian Signature:_____
Date of Signature:_____/_____/_____