FULTZ
PHYSICAL THERAPY & JOINT REHAB

(Please Print Clearly)

Patient's First Name: _____ Last Name: _____ Middle: _____

Mailing Address: _____ City: _____ St: _____ Zip: _____

Street Address: _____ City: _____ St: _____ Zip: _____

DOB: ___ / ___ / ___ Patient's SS#: ___ / ___ / ___ DL #: _____ Gender: Male Female

Hm. Ph#: (___) _____ Cell #: (___) _____ Email: _____

Patient's Status: Married Single Divorced Widowed Other Student: Full-time Part-time

Employment Status: Full-time Part-time Unemployed Self-Employed Retired Disabled

Place of Employment: _____ Occupation: _____

Wk.#: (___)_____ Address: _____ City:_____ St:____ Zip:_____

Spouse's Name: _____ Spouse's DOB: ___ / ___ / ___ Spouse's SS#: ___ / ___ / ___

Spouse's Place of Employment: _____ WK#: (___) _____

Responsible Party/Guardian: (If not the patient; or If patient is a minor (under the age of 18):

First Name: _____ Last Name: _____ Middle: _____

Mailing Address: _____ City: _____ St: _____ Zip: _____

Street Address: _____ City: _____ St: _____ Zip: _____

DOB: ___ / ___ / ___ SS#: ___ / ___ / ___ DL #: _____ Hm. Ph#: (___) _____

Cell #: (___) _____

Place of Employment_____ Wk.#: (___)_____

Address: _____ City: _____ St: ____ Zip: ____

Emergency Contact: _____#(___)_____ Relationship: _____

Primary Care Physician _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:

I authorize the release of any and all medical information necessary to process my claim for services provided by Fult Physical Therapy and Joint Rehab, and request payment of benefits to Fultz Physical Therapy and Joint Rehab, LLC.

I hereby consent to the release and disclosure of my personal health information to Fultz Physical Therapy and Joint Rehab, LLC. This release authorization includes my personal health information consisting of MRI results, test results, et for the purpose of deciding plan of treatment.

Patient's/Responsible Party's Signature: _____ Date: _____

Patient's Name: _____ DOB: ____/____/____ Date completed: _____

Referring Physician: _____ Return Date to Physician: _____

What caused you to seek physical therapy/medical attention? _____

Your condition is related to: Employment Auto Accident Home Other

Date of condition/accident: _____/_____/_____ State Accident Occurred: _____

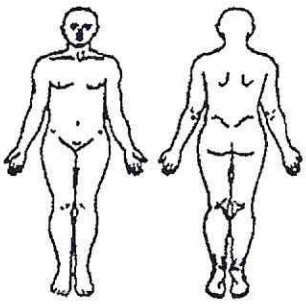
What is your major compliant? Please be as detailed as possible _____

_____

Have you had this problem before? ___ Yes ___ No

Mark the location of your pain with an "X":

FRONT BACK



If you have pain, what is your pain level? (0= No Pain, 10 = Extreme Pain – Circle)

0 1 2 3 4 5 6 7 8 9 10

No Pain Extreme Pain

What make your pain better? _____

What make your pain worse? _____

Is this pain getting: ____ Better _____ Worse _____ Not Changing

What type of treatments have you received for this condition? ____ X-Rays ____Surgery ____Chiropractic ___MRI

____ Medications _____Injection _____Bone Scan _____CT/CAT Scan ____Physical Therapy ____Home Health

Please describe (agency, etc.) _____

Have you fallen in the last 12 months? Yes No If yes, how many times? _____

Did your fall result in any injury? Yes No _____

PLEASE CHECK ALL PROBLEMS DIAGNOSED BY A DOCTOR. CIRCLE IF YOU ARE CURRENTLY BEING TREATED.

___Bronchitis/Emphysema/Lung Disease ___ Sciatica ___Gout ___Heart Disease

___Pneumonia ___Fibromyalgia ___Implants ___ Lupus

___Abnormal Chest X-Ray ___Bursitis ___High/Low Blood Pressure ___Tuberculosis

___Chronic Fatigue Syndrome ___TMJ Dysfunction ___Dizziness/Fainting Spells ___Epilepsy

___Thrombosis/Phlebitis ___Muscular Dystrophy ___Pregnant – due date_____ ____Diabetes

___Carpal Tunnel Syndrome ___ Blood-Borne Pathologies: HIV AIDS Hepatitis A Hepatitis B Hepatitis C

___Tumors/ Cancer—Year_____ Type_____ Remission: Yes No ___Pace Maker—if Yes, date rec'd _____

___Sprains/ Dislocations/Broken Bones—Please List: _____

Please list all medications you are currently taking and what they are for [Specific name of medication, dosage, frequency & Route (Example: by mouth), please include over the counter, prescriptions, herbals & vitamins]: _____

_____

_____

Please list any previous surgeries: _____

_____

Height: _____ Weight: _____

FULTZ PHYSICAL THERAPY
9462 Ellerbe Road, Suite 200
Shreveport, LA 71106

HIPAA ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

Printed Patient Name: _____

Patient Date of Birth: _____

We at Fultz Physical Therapy are required by law to maintain the privacy of health information and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. If you would like a copy of the Notice, please ask.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

_____ _____

Signature of patient or patient's representative/parent Date

_____

Printed name of patient or patient's representative/parent

_____

Relationship to patient