ELGIN
PHYSICAL THERAPY

Patient Information

Patient Name:			Male / Female
Patient Date of Birth: _____/_____/_____	Patient Social Security Number:		
Street Address:	City:	State:	Zip:
Cell Phone:	Home Phone:		
Email:			
I give permission to Elgin Physical Therapy to send appointment reminders as text AND/OR email to the email address / cell number I have provided _____ (initials) Preference: EMAIL TEXT (circle)			
Emergency Contact Name:	Phone:		
Referring Physician:	Primary Care Physician:		

If Patient is under 18 please complete:

Name of Responsible Party	Relationship to Parent	Responsible Party Date of Birth: _____/_____/_____

Have you received home health services within the last month? Yes No (circle)
Have you received physical therapy services this calendar year? Yes No (circle)

PLEASE NOTE, INSURANCE WILL NOT PAY FOR OUTPATIENT THERAPY IF YOU ARE STILL RECEIVING HOME HEALTH SERVICES

NOTICE OF PRIVACY AND PATIENT RIGHTS:
I hereby authorize the use or disclosure of my individually identifiable health information as described in the Notice of Privacy Practices and Patient Rights for Elgin Physical Therapy Clinic. A copy of the Notice of Privacy Practices and Patient Rights will be provided upon my request.

PATIENT AGREEMENT – ASSIGNMENT AND RELEASE
I, undersigned, have insurance coverage with and assign directly to Giddings Physical Clinic Inc., dba Elgin Physical Therapy Clinic, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize release of information necessary to file a claim with my insurance.

Patient or Legal Guardian Signature: _____Date:_____

Witness: _____Date:_____

Brief Medical History

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

How did you hurt yourself? _____

Diagnosis: _____ Date of Injury (DOI): _____ Date of Surgery (DOS): _____

Any Recent Imaging? Examples: X-ray, MRI, CAT, EMG_____

Any past conditions/injury/surgery related to your current pain (PMH): Y / N Explain:_____

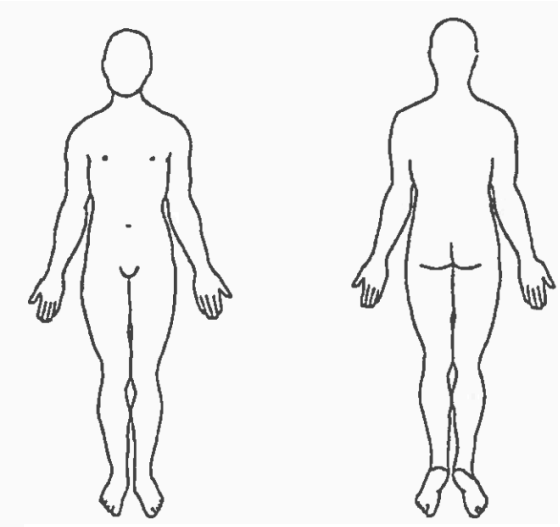
Are you working: Y / N What is your job title: _____ # of years working: _____

What positions, movements, activities are difficult (circle): sitting / standing / bending / twisting kneeling / squatting /sit-to-stand walking / up/down stairs / reaching / gripping / grasping / lifting / carrying / other: _____
What does it feel like (circle): burning / sharp / dull / achy / throbbing / shooting / numbness / tingling / constant / intermittent

NO PAIN <----------> SEVERE PAIN

How intense is your pain currently (circle):	0 1 2 3 4 5 6 7 8 9 10
How intense is your pain at best (circle):	0 1 2 3 4 5 6 7 8 9 10
How intense is your pain at worst (circle):	0 1 2 3 4 5 6 7 8 9 10

Fall History: Injury as a result of a fall in the past year? Y / N Two or more falls in the last year? Y / N



Body Chart:
Please mark the areas where you feel pain on the chart to the right with the following symbols to describe your pain:

||| **Numbness**
= **Tingling/Prickling (e.g electrical tingling/crawling ants)**
↓ **Shooting/sharp pain**
O **Dull/ache pain**

Do you now or have you ever had any of the following? (CIRCLE)

Arthritis	Heart Attack
Anxiety	Hearing Problems
Allergies	Metal Implants
Bowel/Bladder Problems	Osteoarthritis
Balance Problems	Osteoporosis
Cancer	Pacemaker
Concussion or TBI	RA
Depression	Stroke
Diabetes	Seizure
Dizzy Spells	Stroke - CVA
Fibromyalgia	Shortness of Breath
Fracture	Urinary Problems
Heart Disease	Vision Problems
High Blood Pressure	
High Cholesterol	Do you smoke? YES / NO
	Do you drink? YES / NO
	Do you exercise regularly? YES / NO
	Currently Pregnant? YES / NO

Signature: _____

MEDICATION LIST

If you have an updated medication list please provide that to the office or therapist. If you do not, please list current medications below.

Medication Name:	How much?