HARBOR
PHYSICAL THERAPY, PC

Date: _____

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Email Address: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Sex: M F

Occupation: _____ Employer: _____

Employer Address: _____

Primary Care Physician Name: _____ Phone: _____

Referring Physician Name: _____ Phone: _____

Parent/Guardian Information for Minors

1. Name: _____ Relationship to Patient: _____

   Home Phone: _____ Cell: _____ Work Phone: _____

2. Name: _____ Relationship to Patient: _____

   Home Phone: _____ Cell: _____ Work Phone: _____

Emergency Contact

Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell: _____ Work Phone: _____

How did you hear about Harbor Physical Therapy?

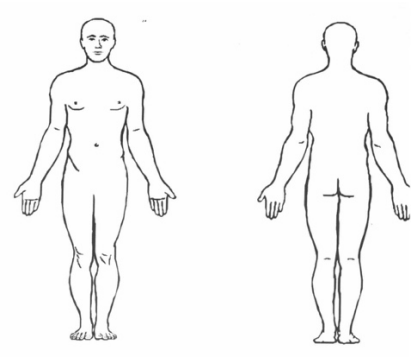
☐ Insurance Company ☐ Internet/Google ☐ Previous Patient ☐ Advertisement

☐ Physician:_____ ☐ Other Person:_____

Please fill out to the best of your ability. These details will help your therapist with the evaluation.

Pain:

1. Please mark on the picture to the right where you have pain or other symptoms.
2. Please describe your pain (Circle those that apply):
   - Localized or Radiating
   - Constant / Frequent / Intermittent
   - Sharp / Dull / Burning / Electrical /Throbbing
   - Deep / Superficial
   - Other:_____



3. Please rate your pain on the following scale: (No pain = 0)

(Lowest) 0 1 2 3 4 5 6 7 8 9 10 (Highest)

Symptoms:

1. Date of injury/ onset of symptoms: _____
2. Cause of injury: ☐ Car Accident ☐ Work-related ☐ Sport ☐Unknown ☐ Other:_____
3. Please describe your injury/symptoms: _____
   _____
4. Since the onset, are you symptoms: ☐ Getting better ☐ The same ☐ Getting worse
5. Previous history of current problem: ☐ Yes ☐ No ☐ Unsure
6. Previous treatment for current problem (if applicable): _____
   _____

Past/Current Medical History:

☐ No significant past medical history

☐ Cardiac arrhythmia	☐ Depression	☐ MS	☐ Pregnant (Currently)
☐ Asthma	☐ Diabetes	☐ Mitral Valve Prolapse	
☐ Cancer	☐ Fractures	☐ Osteoporosis	☐ Rheumatoid Arthritis
☐ Congestive Heart Failure	☐ Heart Attack	☐Osteoarthritis	☐Vascular Disease
☐ COPD	☐ Hypertension	☐ Pacemaker	

☐ Other: _____

☐ Other: _____

History of Falls: ☐ No History ☐ Yes – If yes, how many in the past year? _____

History of: ☐ Alcohol ☐Substance Abuse ☐ Smoking: Packs/day:_____ ☐ Other:_____

Past/Current Surgical History:

☐ No Significant History

☐ Ankle Surgery Left / Right	☐ Total Hip Replacement Left / Right	☐ Cardiac Bypass
☐ Elbow Surgery Left / Right	☐ Total Knee Replacement Left / Right	☐ Cancer Surgery
☐ Hand Surgery Left / Right	☐ Shoulder Replacement Left / Right	☐ Pacemaker Placement
☐ Knee Surgery Left / Right	☐ Shoulder Surgery Left / Right	☐ Spine Surgery

☐ Other (Please Specify):_____

Allergies:

☐ No known allergies
☐ Latex ☐ Seasonal/Environmental ☐ Medications (Please List):_____
☐ Other (Please List):_____

_____ _____
Patient/Guardian Signature Date

Medicare Patient Must Fill the Following Two Sections- Required by Medicare

Height and Weight

Height (inches): _____ Weight (pounds): _____

Medications

Medication	Dosage (Amount taken)	Frequency (How often is it taken)	Administration Route (How is it taken)

Patient Name: _____

CONSENT TO TREATMENT:
I agree and give my consent to receive physical therapy and related services that are considered appropriate and necessary at Harbor Physical Therapy, P.C.

Patient and/or Guardian Signature:_____ Date:_____

MEDICAL RECORDS AND INFORMATION RELEASE:
I agree to authorize the release of medical records and/or other information related to my condition and care while under the care of Harbor Physical Therapy, P.C. in accordance with the Notice of Privacy Practices.

Patient and/or Guardian Signature:_____ Date:_____

AUTHORIZED ASSIGNMENT OF BENEFITS AND PAYMENT:
I authorize and assign direct payment of medical/physical therapy benefits to Harbor Physical Therapy, P.C. for services rendered. I understand in the event my insurance company or financially responsible party does not pay for the services received, I will be financially responsible for payment.

Patient and/or Guardian Signature:_____ Date:_____

PERSONAL PROPERTY:
I understand and agree that Harbor Physical Therapy, P.C. is not responsible for the loss or damage of personal property within the facility.

Patient and/or Guardian Signature:_____ Date:_____

CANCELLATION AND MISSING APPOINTMENT POLICY:
I understand that Harbor Physical Therapy, P.C. has the right to charge me $25.00 for any missed appointment and/or excessive cancellations within 24 hours of the appointment time. These charges will be made at the discretion of Harbor Physical Therapy, P.C.

Patient and/or Guardian Signature:_____ Date:_____

NOTICE OF PRIVACY PRACTICES:
I have been given and/or reviewed the Notice of Privacy Practices for Harbor Physical Therapy, P.C.

Patient and/or Guardian Signature:_____ Date:_____