PATIENT'S NAME: ______________________________ **DATE:** ____________________
First MI Last

SSN# ____________________ **DOB** ________________ **AGE** ______ **SEX: M** ☐ **F** ☐

ADDRESS ____ **APT#** ____________

CITY ________________________ **STATE** ______________ **ZIP** __________ - ________

***E-MAIL ADDRESS** ____

*(PLEASE COMPLETE – appointment confirmations will be sent by email)

HOME PHONE (_____) ______-_________ **CELL PHONE** (_____) ______-_________

WORK PHONE (_____) ______-_________ **EMPLOYEER:** ____________________________

PROFESSION: ____________________________ **RETIRED? Y** ☐ **N** ☐

SPOUSE'S NAME: ____________________________________ **PHONE** (_____) ______-_________
First MI Last

EMERGENCY CONTACT NAME: ______________________ **RELATIONSHIP TO PATIENT:** ________________

PHONE (_____) ______-_________ **CHECK ONE:** ☐ **OFFICE** ☐ **HOME** ☐ **CELL** ☐ **OTHER**

***REFERRING PHYSICIAN:** ____________________________________ **PHONE** (_____) ______-_________

ADDRESS ________________________ **CITY** ______________ **STATE** _____ **ZIP** ________-______

***PRIMARY PHYSICIAN:** ____________________________________ **PHONE** (_____) ______-_________

ADDRESS ________________________ **CITY** ______________ **STATE** _____ **ZIP** ________-______

☐ Please send my primary physician a copy of my Physical Therapy evaluation report.

NEUROLOGIST: ________________________ ☐ please send this doctor a copy of my evaluation

EAR NOSE & THROAT (ENT): ________________________ ☐ please send this doctor a copy of my evaluation

CARDIOLOGIST: ________________________ ☐ please send this doctor a copy of my evaluation

Are you currently being seen by any of the following?

☐ Physical Therapist ☐ Speech Therapist ☐ Occupational Therapist ☐ Psychiatrist/Psychologist

If you are seeing any of the above, please describe the reason: ____________________________________

Have you had therapy for current symptoms? ☐ **Yes** ☐ **No**

If you answered yes, please explain where and when, and the outcome of the therapy: ______________________

Worker's Compensation Only: Date of Injury: ____________________

Please provide a brief description of your injury:

____

____

PRIMARY INSURANCE INFORMATION

(PLEASE COMPLETE THIS SECTION IN FULL; WE WILL COPY FRONT / BACK OF INSURANCE CARD)

INSURANCE CO ________________________ **Member ID:** ______________ **Group #:** __________

* **PRIMARY POLICY HOLDER'S NAME** ___________________________ **SSN#** ___________________

SECONDARY INSURANCE INFORMATION

(PLEASE COMPLETE THIS SECTION IN FULL; WE WILL COPY FRONT / BACK OF INSURANCE CARD)

INSURANCE CO ________________________ **Member ID:** ______________ **Group #:** __________

* **PRIMARY POLICY HOLDER'S NAME** ___________________________ **SSN#** ___________________

RELEASE OF MEDICAL INFORMATION ________ **initials**

I authorize EQUILIBRIUM Balance Performance Center, PT, Inc to release medical records concerning my self / son / daughter / other dependent to any physician, hospital, or agency involved in the care of the patient listed.

ASSIGNMENT OF MEDICAL BENEFITS ________ **initials**

I authorize my insurance carrier to assign medical benefits to EQUILIBRIUM Balance Performance Center, PT, Inc. I also authorize release of medical information necessary to process all medical insurance claims.

PAYMENT POLICY ________ **initials**

Co-payments are due at the time services are received. We accept cash and check only at this time. All medical services provided are directly charged to the patient or responsible party. If our clinic is contracted with your insurance carrier, we will accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility / non-payable / non-covered by your insurance company and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office.

CANCELATION POLICY ________ **initials**

Our office requires that if an appointment needs to be cancelled, we receive notice **no later than 5pm on the previous business day** prior to your scheduled appointment. Please note, our business days are Tuesday through Friday. Cancellations for Tuesday must be received by 5PM on the preceding Friday. Cancellations and no show fees are the patient's responsibility and will not be billed to your insurance. Fee payments are due on or before your next appointment. **I, the patient, agree to pay a $50.00 fee for each** late **cancellation and no show appointment**.

REFERRAL POLICY ________ **initials**

I understand it is my responsibility to obtain a prescription from my referring physician's office to receive therapy services. Failure to do so will result in charges being billed in full directly to myself. In addition, all therapy services will be placed on hold until the physician's prescription for therapy services is received.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION, PAYMENT POLICIES AND CLINIC POLICIES:

X ____________________________________ **X** ________________________

SIGNATURE OF RESPONSIBLE PARTY **DATE, READ, AND SIGN**

PATIENT'S NAME: ______________________________ **DATE:** ______________
First **MI** **Last**

PATIENT QUESTIONNAIRE

DIAGNOSIS: (reason you are here):______________________________

Are you currently being seen by any of the following?

☐ Physical Therapist ☐ Speech Therapist ☐ Occupational Therapist ☐ Psychiatrist/Psychologist

If you are seeing any of the above, please describe the reason:______________________________

Have you had therapy for this recent illness? ☐ Yes ☐ No

If you answered yes, please explain where and when, and the outcome of the therapy: ______________________________

INITIAL ONSET DATE OF SYMPTOMS/EXACERBATION: ____ / ____ / ______

PRIMARY SYMPTOMS: ______________________________

WHAT CAUSED YOUR SYMPTOM ONSET/EXACERBATION? ______________________________

MEDICAL HISTORY RELATED TO YOUR CURRENT SYMPTOMS: ______________________________

SEVERITY OF SYMPTOMS: (rated 0-10) **Severity of Pain** _____ **/ 10**

WHAT AGGRAVATES YOUR SYMPTOMS? ______________________________

ACTIVITIES RESTRICTED DUE TO CONDITION: ______________________________

OTHER MEDICAL HISTORY: Have you had or do you suffer from: (Check all that apply)

☐ Heart problems ______________________________
☐ Diabetes
☐ Stroke/Neurological
☐ Multiple Sclerosis
☐ Parkinson's Disease
☐ Seizures/Convulsions
☐ Kidney disease
☐ Cancer
☐ Life threatening infection
☐ Cardiac/heart disease
☐ Fibromyalgia
☐ Rheumatoid Arthritis
☐ Depression
☐ Do you drink alcohol? ☐ Yes ☐ No how much?_________ Use tobacco? ☐Yes ☐ No packs/day_____
☐ Use recreational drugs? Have a dependency on prescription drugs? ☐ Yes ☐ No how much?_________
☐ Recent flu/Virus (please specify):______________________________

☐ **Musculoskeletal conditions** – ***(please list)*** ______________________________

MEDICATION

Are you currently taking any medication for your condition? ______________________________

PREVIOUS LEVEL OF FUNCTION

Describe: ____

____

CURRENT LEVEL OF FUNCTION

Describe: ____

____

In your words, please describe what you would like to achieve / improve by coming to Physical Therapy:

- ____
- ____
- ____