Date:_________ First Name:________________ Last Name:______________________ Middle Initial:___

Address:____ State:_____ Zip:________

Date of birth:________________ Home phone:________________________ Cell:____________________

Spouse:_____________________ Emergency Contact:__________________________ PH#____________

Employer:__________________________________ Occupation:_________________________________

Check one: Full time___ Part time___ Retired___ Not employed___

Referring Doctor:______________________________ Phone #:________________________________

Reg doctor/PCP:_______________________________ Phone#:_________________________________

Insurance Name:____

Subscribers name, if different (ex. Spouse or parent):_______________________________________

ID#_______________________________________ Group policy#________________________________

Secondary Insurance:_____________________ ID#____________________ Group/policy#__________

Subscribers name, if different:_________________________

How did you hear about us?____

I authorize my insurance benefits be paid directly to Edwards Physical Therapy and understand that I am financially responsible for any balance that I may owe. I also allow Edwards PhysicalTherapy to release/share any information required to process my claims.

Under federal law, your patient health information (PHI) is protected and confidential. Patient health information (PHI) includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your patient health information (PHI) also includes payment, billing and insurance information. We are committed to protect the privacy of your PHI.

Patient/Guardian Signature:____

MEDICAL HISTORY:

Do you have any of these following conditions? Please check if any apply.

Blood pressure: Hypertension___ Low blood pressure____

Heart disease: Heart attack____ Angina____ Atherosclerotic disease____ Rheumatic heart disease____

Murmur___ Atrial fibrillation___ Congestive heart failure CHF____ **Do you have a Pacemaker?** ____

Lungs: Asthma___ Emphysema___ Shortness of breath ___ Have been diagnosed with COPD___

Muscle conditions: Tendonitis___ Muscle tightness___

Joint problems: Osteoarthritis___ Where?_________________Swelling?___ Where?_______________

Mental: ___Depression ___Bipolar ___Schizophrenia____Anxiety___Panic attacks____

Other: Epilepsy___Muscle spasm___Multiple Sclerosis___Gout___Fibromyalgia ___Diabetes___
Hearing loss___Vision loss___**Cancer**___Vertigo___Balance problems___**Falls**____**Pregnant?**____

Other:____

Any prior related work or automobile injuries?____ If so when?_______________________________

Medicines and supplements:____

____

____

____

Do you take seizure medication or any medications that affect your heart?______________________

Surgeries:____

____

Height:_____ Weight:_______

Exercise: _____None _____1-2 x wk _____3-4 x wk or more. What type?_________________________

Work conditions: ___frequent sitting ___frequent standing ___ Heavy labor ___Work nights

Stress level: ____Low ____Medium ___High Why?____

Habits: ___Smoke (__packs/day) ___Alcohol(Drinks per week____) __Coffee/Soda (cups per week___)

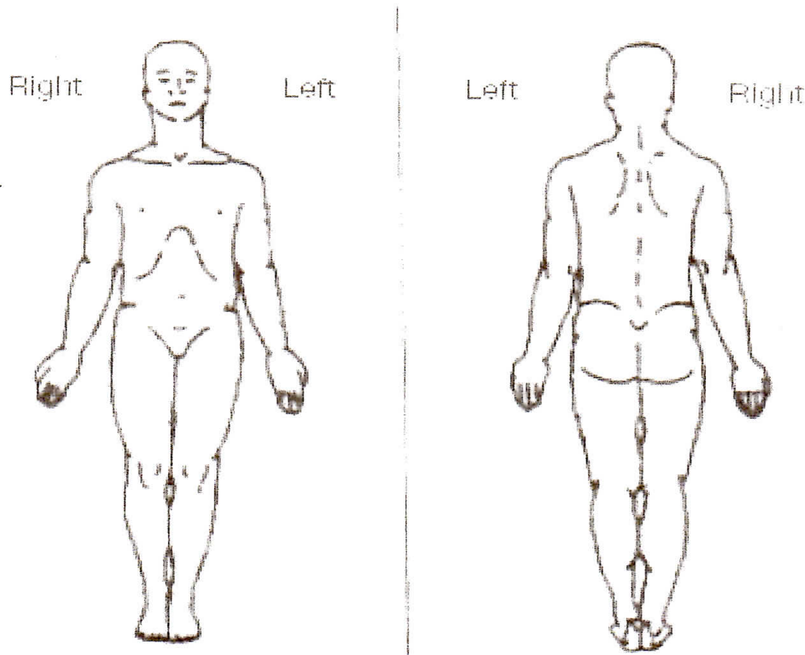
Have you had Chiropractic or PT treatment before? ____Where?______________________________

Patient/Guardian Signature:____

Pain and symptoms

Using the diagram and symbols outlined. Please draw them on the locations where you are having those symptoms.

Pain- X   Ache - A   Numbness -N   Burning -B   Pins and needles-P



Date when symptoms first started:_______________

My chief complaint is:____

2nd complaint:____

Please rate your pain by circling a number. (0 being none and 10 being worst you can imagine).

Worst it has been:	0	1	2	3	4	5	6	7	8	9	10
Currently:	0	1	2	3	4	5	6	7	8	9	10
Best it has been:	0	1	2	3	4	5	6	7	8	9	10

Patient/Guardian signature:____

Auto or Work Injury Information:

Auto:_____ Workers Comp:____ (check one)

Insurance Name:____

Insurance Address:____

Adjuster/ Claim Manager:_______________________Phone#___________________________

Claim#____Date of Injury:____________

Cause of injury:____

Attorney name:__________________________Law firm:_____________________________

Address:____________________________________Phone:_________________________

We would like to make you aware that auto insurance companies cover physical therapy benefits as long as there is Personal Injury Protecton (PIP) available on the claim. We do check and verify if PIP is available and that the claim is open and active and that it exists. However adjustors are unable to reveal the total dollar amount remaining. Therefore it is your responsibility to know and understand what benefits and amounts covered by your auto insurance. We will continue to bill your auto insurance until PIP has been exhausted and the claims are denied. As backup to bill these potentially denied claims, it is our policy to obtain your private medical insurance information in addition to your auto insurance. If you do not have medical insurance or do not wish to provide that information, all denied and unpaid balances will be your responsibility. Please let us know if you have any questions about this information.

Patient/Guardian signature:__________________________________Date:_________________