Confidential Medical History/Evaluation

Date: _____/_____/_____

Name: _____ **Date of Birth**: _____/_____/_____ **SS#**:_____

Phone #(s): home/cell/work_____

Address: _____City_____State_____Zip_____

Marital Status: Married Single Other **Employment status**: Full Time Part Time Student Other **Employer**: _____

Email Address: _____ **Ok to leave messages y/n**: ____ Phone ____Email?

Insurance Company: _____ **Primary Subscriber's Name & DOB (i.e. spouse or parent)**:_____

Emergency Contact Name and Phone #:_____

Referring MD: _____ **Primary Care Physician**: _____

Chief Complaint: _____ **Date of Injury**: _____

Current Symptoms: Pain Numbness Stiffness Weakness _____ **Condition:** New Acute Chronic Recurring

Medications: _____ **Height: _____ Weight: _____**

Allergies? _____ **List any surgeries**: _____

Previous Diagnostic or Rehabilitative Services for this (or other) Injury? MRI X-rays Results/other: _____

Do you have any of the following?

	YES	NO		YES	NO
Asthma, Bronchitis or Emphysema	____	____	Cancer or Chemo/Radiation	____	____
Shortness of Breath/Chest Pain	____	____	Arthritis/Swollen Joints	____	____
Coronary Heart Disease	____	____	Osteoporosis	____	____
Do you have a Pacemaker	____	____	Varicose Veins	____	____
High Blood Pressure	____	____	Gout	____	____
Heart Attack/Surgery	____	____	Sleeping Difficulties	____	____
Stroke/TIA	____	____	Emotional/Psychological Problems	____	____
Blood Clot/Emboli	____	____	Bowel or Bladder Problems	____	____
Epilepsy/Seizures	____	____	Severe/Frequent Headaches	____	____
Thyroid Trouble/Goiter	____	____	Vision/Hearing Difficulties	____	____
Anemia	____	____	Dizziness or Faintness	____	____
Infectious Disease	____	____	Are you pregnant?	____	____
Diabetes	____	____			

Sports/ Recreational Activities _____

Exercise _____ x Week, Describe _____

Smoking Daily _____ Weekly _____

Alcohol Consumption Daily _____ Weekly _____

Number of Caffeinated beverages per day: _____ Ounces of water per day: _____

Other Medical Conditions_____

Are you aware of your Diagnosis? YES ___ NO ___ Are you aware of your Prognosis? YES ___ NO ___

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Optimal Physical Therapy, LLC, regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

XPatient/Parent/Guardian Signature: _____Date:_____