PATIENT INFORMATION

PATIENT NAME________________________________MALE/FEMALE? DATE______________________________

ADDRESS____DATE OF BIRTH______________________

CITY____ STATE___________ ZIP_____________________

HOME PHONE____________________________________CELL PHONE____

WORK PHONE____________________________________DRIVERS LICENSE #_________________________________

SOCIAL SECURITY NUMBER_______________________________SURGERY DATE_____________________________

REFERRING DOCTOR______________________________________INJURY DATE______________________________

LOCATION OF PAIN/INJURY________________________________IS THIS A WORK RELATED INJURY? YES NO

JOB TITLE____EMPLOYER_______________________________

IS THIS INJURY FROM A CAR OR OTHER ACCIDENT? YES NO

ATTORNEY NAME____ PHONE_______________________________

EMERGENCY CONTACT NAME________________________________PHONE___________________________________

Responsible Party (Guardian)__________________________________ Date of Birth___________________________

Responsible Party SS#:_____________________________Drivers License #:____________________________________

INSURANCE INFORMATION

Name of Insured____S.S. #_______________________________________

Patients Relationship to Insured:____

Insurance Company_______________________________________ Phone #____

Claim/ID #____Adjustor____

I give permission to Alameda/Pacific Physical Therapy to release information to my insurance company, attorney, assignees, and/or beneficiaries. I authorize payment directly to Alameda/Pacific Physical Therapy for services that I or a dependent has received by my insurance carrier. In consideration of the services rendered and to be rendered to the above named patient by Alameda/Pacific Physical Therapy, I expressly guarantee payment of this account and agree to pay any charges left unpaid in whole or in part by my insurance carrier. I understand that Alameda/Pacific Physical Therapy will verify benefits and coverage with my insurance carrier, but that this does not guarantee payment by my insurance carrier. I also understand that I may be liable for reasonable collection fees, interest and other costs for any unpaid debt incurred. I also understand that Alameda/Pacific Physical Therapy has a 24 hour cancellation policy and that I may be liable for a $50.00 No-Show/Cancellation Fee for repeat offenses of this policy and prior to any further appointments scheduled.

X____Date_________________________
Signature by Patient or Person Responsible for Patient

X____
Print Name

Type of work, examples: lifting, prolonged sitting, standing, keyboarding, etc.____________________________________

How did the injury occur?____

Present Complaint:____

Current Medical Problems:____

Do you have any current or previous history of:

Allergies to heat/ice	Yes No	Heart Attack	Yes No
Anemia	Yes No	Heart Condition	Yes No
Angina (chest pain)	Yes No	Hernia	Yes No
Aortic Aneurysm	Yes No	Kidney Disorders	Yes No
Arthritis	Yes No	Metal Implants	Yes No
Asthma	Yes No	Pacemaker	Yes No
Blood Pressure (high or low)	Yes No	Prostate Problems	Yes No
Cancer	Yes No	Rapid Heart Beat	Yes No
Depression	Yes No	Seizures	Yes No
Diabetes	Yes No	Strokes	Yes No
Emphysema	Yes No	Thyroid	Yes No
Headaches	Yes No	Ulcers	Yes No

Other____

Have you been admitted to the hospital or undergone any surgical procedures during the last 5 years? Yes No

What was the condition?____

Is the condition the reason you were referred to Physical Therapy? Yes No

Have you received any physical therapy treatments during the past 5 years? Yes No If yes, for what condition and was the treatment effective?____

What did the treatment consist of?____

Did you receive any special tests while in the hospital or as an out-patient? Examples: x-ray, MRI, EMG, CT Scan, EKG

Yes No If yes, please specify____

Have you had any previous orthopedic problems? Yes No If yes, please specify___________________________

____

Which medications are you taking and for what?____

____

Are you pregnant? Yes No If yes, when is the baby due?____

Exercise/activity level: _____0 days/week ________1-2 days/week _________3-5 days/week _________5-7 days/week

Describe exercises/activities____

Consent to Treatment

I have been informed by POSR/AOST of the treatment and care, which my physician has prescribed. I understand as a patient, I am under the care and control of my physician and that POSR/AOST is not liable for any act or omission when providing treatment in accordance with my physician's instructions. I acknowledge that no guarantee or assurance has been, nor can be made, by POSR/AOST as to the results of the prescribed treatment. Must be signed by guardian if the patient is a minor (under 18).

Signature____ Date____________________________________

Print Name____

Pacific Physical Therapy	Pacific Physical Therapy	Alameda Physical Therapy
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Hayward, CA 94541	Emeryville, CA 94608	Alameda, CA 94501
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510-247-9971 (fax)	510-923-0500 (fax)	510-521-5096 (fax)