

## Body Owners Physical Therapy & Wellness Center Patient Information

PATIENT REGISTRATION						
PATIENT NAME (FIRST, MIDDLE, LAST)					HOME PHONE	
HOME ADDRESS			CITY	STATE	ZIP	CELL PHONE
SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	AGE	MARITAL STATUS	EMAIL	
EMPLOYER ADDRESS				OCCUPATION	WORK PHONE	
REFERRING PHYSICIAN (NAME, ADDRESS, PHONE)			PRIMARY CARE PHYSICIAN (NAME, ADDRESS, PHONE)			
EMERGENCY CONTACT INFORMATION						
NAME AND ADDRESS				PHONE	RELATIONSHIP TO PATIENT	
PRIMARY INSURANCE INFORMATION						
INSURANCE COMPANY			ADDRESS			PHONE
SUBSCRIBER'S NAME			SUBSCRIBER DOB	SUBSCRIBER'S SS#	RELATIONSHIP TO PATIENT	
GROUP NUMBER	ID/CLAIM/POLICY #			ADJUSTER NAME AND PHONE NUMBER		
SECONDARY INSURANCE INFORMATION						
INSURANCE COMPANY			ADDRESS			PHONE
SUBSCRIBER'S NAME			SUBSCRIBER DOB	SUBSCRIBER'S SS#	RELATIONSHIP TO PATIENT	
GROUP NUMBER	ID/CLAIM/POLICY #			ADJUSTER NAME AND PHONE NUMBER		
OTHER INFORMATION						
DO YOU HAVE TERTIARY INSURANCE?						
IS YOUR INJURY RELATED TO A MOTOR VEHICLE ACCIDENT?		DATE OF ACCIDENT	IS YOUR INJURY RELATED TO WORK (WORKERS COMPENSATION)?		DATE OF INJURY	
WHERE DID THE ACCIDENT OCCUR (NAME/ADDRESS/PHONE NUMBER)?						
CO-PAY/CO-INSURANCE PAYMENTS REQUIRED AT TIME OF SERVICE						
Credit card -- VISA    MASTERCARD    DISCOVER    AMERICAN EXPRESS    -- Please circle one						
CREDIT CARD NUMBER			EXPIRATION DATE	V-CODE (THREE DIGIT CODE ON BACK OF CARD)		
CARD HOLDER NAME			CARD HOLDER ADDRESS			
SIGNATURE				DATE		

I consent to treatment necessary for the care of the above named patient.

I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.

I allow fax transmittal of my medical records, if necessary.

I acknowledge full financial responsibility for services rendered by Body Owners Physical Therapy & Wellness Center and their professional staff and authorize transfer of all unpaid amounts to my credit card after 120 days from the date of service.

I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.

I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**PAST MEDICAL HISTORY AND INFORMATION FORM**  
**PATIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_**

1. What are your present complaints or symptoms?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. How did you get injured?

\_\_\_\_\_

3. What other treatment have you received?

\_\_\_\_\_

4. Have you ever had a similar condition \_\_\_\_\_

5. Did you have surgery?

\_\_\_\_\_

a. Where \_\_\_\_\_

When \_\_\_\_\_

b. What part of your

body \_\_\_\_\_

c. What procedure was

done \_\_\_\_\_

6. What **Medications** are you currently taking? Please list **ALL** medications the purpose of the medication if the name is unknown:


7. Do you currently work? Y or N      Where?

\_\_\_\_\_

a. Occupation \_\_\_\_\_ Duties \_\_\_\_\_

b. If you recently stopped working when did you stop?

\_\_\_\_\_

8. How active are you? Please describe the level and list activities you enjoy:

\_\_\_\_\_  
\_\_\_\_\_

9. Do you have pain? YES OR NO/ Rate your **pain** on a scale of 10 (10 = extreme pain & 0 = no pain) \_\_\_\_\_ At Rest \_\_\_\_\_ With Activity

\_\_\_\_\_

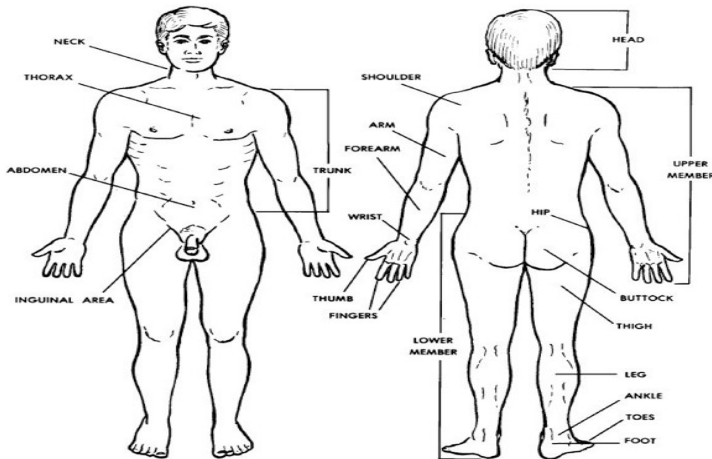
10. What activity or positions **increase** your pain?

\_\_\_\_\_

11. What do you do to **decrease** your pain?

\_\_\_\_\_

### LOCATE YOUR SYMPTOMS



### ***PLEASE LIST ANY PAST MEDICAL HISTORY/ CONDITIONS/ALLERGIES***

\_\_\_\_\_  
What are your expectations for physical or occupational therapy?  
\_\_\_\_\_  
\_\_\_\_\_

Signs and Symptoms  
(Check for yes, leave blank for no)

- |                          |                      |
|--------------------------|----------------------|
| 18. Tingling _____       | Arm Pain _____       |
| Numbness _____           | Dizziness _____      |
| Burning _____            | Frequent Colds _____ |
| Nose Bleeds _____        | Chest Pain _____     |
| Fatigue _____            | Fainting _____       |
| Frequent headaches _____ | Convulsions _____    |
| Recent fever _____       | Abdominal Pain _____ |
19. What are the characteristics of your pain or symptoms?
- |               |                          |
|---------------|--------------------------|
| Sharp _____   | Constant _____           |
| Dull _____    | Frequent _____           |
| Burning _____ | Occasional _____         |
| Numb _____    | Intermittent _____       |
| Tingle _____  | Radiating _____          |
| Sore _____    | Sleep Interrupted? _____ |
| Other _____   |                          |

Conditions and disorders  
(Past or Current)

20. Osteoarthritis (general joint arthritis) \_\_\_\_\_
- |  |                                  |
|--|----------------------------------|
| Heart Murmurs _____  | Bladder Problems _____           |
| Cardiac Disease _____  | Family History of Cancer _____   |
| Bypass Surgery _____   | Personal History of Cancer _____ |
| Where and When? _____  | Anxiety Disorder _____           |
| High Blood Pressure _____  | Epilepsy _____                   |
| Controlled with medicine or diet? _____  | Pneumonia _____                  |
| Diabetes _____   | Tuberculosis _____               |
| Controlled with insulin or diet? _____   | Rheumatoid Arthritis _____       |
| Thyroid Disorder _____   | Scarlet Fever _____              |
| Organ Disorder _____   | Any abnormal bleeding _____      |
| Infectious Disease _____   | GI Disorders _____               |
| Kidney Condition _____   | Hepatitis _____                  |
| Menstrual Problems _____   | Insomnia _____                   |
| Anemia _____   |                                  |
| Allergies to medications or others _____   |                                  |
| Other (Conditions or surgeries that would influence your physical therapy) _____ |                                  |
| _____  |                                  |
| _____  |                                  |