MEDICAL HISTORY/EVALUATION

Date: _____
Name:_____
Email Address:_____
Insurance Type:_____
General Benefits:_____
Patient Responsibility:
CoPay:____Per:_____Deductible:_____%Responsible:_____

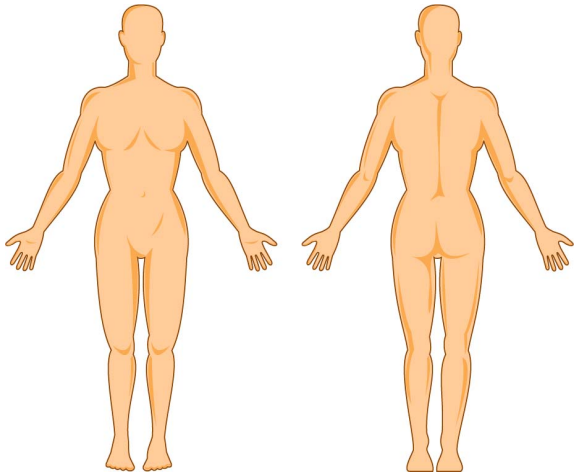
_____

Referring Physician:_____ Family Physician:_____
Date of Injury/Onset:_____
Current Work Status:_____ Last Date worked due to injury: _____
Level of Activity: _____
Is an Attorney involved in this case: **YES** **NO**
Have you had any diagnostic tests for this injury? **YES** **NO**
If so, what type? (I.e. X-rays, MRI, other)_____When?_____
Have you had surgery for this injury? **YES** **NO**
If so, what type of surgery and when?_____
Current Medications:_____
Age:_____ Weight:_____ Height:_____ Avg Blood Pressure:_____
Have you had any falls? **YES** **NO**
How has pain changed since onset?_____
Goals you expect from therapy:_____
Are you receiving home health services? _____If so, with whom?_____
When were you discharged?_____

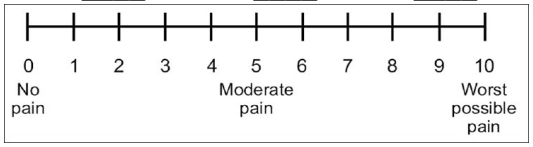
Please check all that apply to you:

- ☐ PAIN
- ☐ SHORTNESS OF BREATH
- ☐ HEART DISEASE/CHEST PAIN
- ☐ DO YOU HAVE A PACEMAKER?
- ☐ HIGH BLOOD PRESSURE
- ☐ STROKE/TIA
- ☐ BLOOD CLOT
- ☐ SEIZURES/EPILEPSY
- ☐ THYROID PROBLEMS
- ☐ INFECTIOUS DISEASE
- ☐ OSTEOPOROSIS
- ☐ DIABETES
- ☐ CANCER - if so, where and When:_____
- ☐ ARTHRITIS
- ☐ GOUT

Indicate where pain is:



Best:____Current:____Worst: ____



- ☐ DRINK ALCOHOL
- ☐ SLEEPING PROBLEMS
- ☐ SEVERE/FREQUENT HEADACHES
- ☐ EMOTIONAL PROBLEMS
- ☐ VISION/HEARING PROBLEMS
- ☐ POOR ENDURANCE
- ☐ DIZZINESS/FAINTING
- ☐ WEAKNESS: if so, where:_____
- ☐ ALLERGIES
- ☐ DO YOU SMOKE? If so, how often?_____
- ☐ ARE YOU PREGNANT?

CONSENT TO TREAT:

I hereby agree and give consent to medical treatment and 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 ESPT 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.

Patient/Parent Signature:_____ Date:_____

HIPPA:

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.

Patient/Parent Signature:_____ Date:_____

CANCELLATION POLICY:

It is Eastern Shore Physical Therapy's goal to provide superior physical therapy to each and every patient. In order to meet our goal, each patient has their own time slot scheduled for therapy. Consequently, we try to avoid unscheduled no shows and cancellations.

I understand that if I miss more than three (3) appointments, Eastern Shore Physical Therapy will bill me $25.00. In order to respect everyone's precious time, Eastern Shore Physical Therapy requests that you cancel your appointments at least 24 hours in advance.

By signing this, I agree to Eastern Shore Physical Therapy's Cancellation Policy.

Patient/Parent Signature:_____Date:_____