



First Name: _____ M.I. _____ Last Name: _____ DOB: _____

Primary Phone: _____ Cell/Home/Work Secondary Phone: _____ Cell/Home/Work SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation/employer: _____ Health insurance co.: _____

Body part to be treated? _____ Date Of Injury/Onset: ____/____/____

Is this injury related to a motor vehicle accident? Yes or No Is this injury related to a workers compensation claim? Yes or No

Have you had surgery related to this physical therapy referral? _____ Date of surgery ____/____/____

Have you had any imaging for this injury? MRI X-Rays Other: _____

Have you recently received home health? Yes or No. If yes, ending date and agency name: _____

Marital Status: _____ Emergency Contact: _____ Phone: _____

Referring DR: _____ Primary DR: _____

Policy Holder: _____ DOB: _____ Employer: _____

Are you currently receiving treatment from a chiropractor or massage therapist? Yes or No Last treatment date _____

Height: _____ Weight: _____ Current use --- Tobacco: Y or N Alcohol: Y or N

How did you hear about us? _____

I would like to receive appointments reminders (check ONE): Text Call E-mail (address: _____)

I give permission for H&B to discuss my medical condition and treatment with: _____

Check if you have a history of any of the following.

- ___ Asthma, Bronchitis or Emphysema
___ Shortness of Breath/Chest Pain
___ Coronary Heart Disease
___ High Blood Pressure
___ Epilepsy/Seizures
___ Anemia
___ Diabetes
___ Arthritis/Swollen Joints
___ Varicose Veins
___ Sleeping Difficulties
___ Bowel or Bladder Problems
___ Vision/Hearing Difficulties
___ Are You Pregnant?

Do you have a Pacemaker?

- ___ Heart Attack/Surgery
___ Stroke/TIA
___ Blood Clot/Emboli
___ Thyroid Trouble/Goiter
___ Infectious Disease
___ Cancer or Chemo/Radiation
___ Osteoporosis
___ Gout
___ Emotional/Psychological Problems
___ Severe/Frequent Headaches
___ Dizziness or Faintness
___ Do you take blood thinners?

Check if you have had any of the following in the past six months.

- ___ Unexplained weight loss
___ Numbness or Tingling
___ Fever, Chills, Sweats
___ Change in appetite
___ Nausea/Vomiting
___ Poor balance/Falls
___ Difficulty swallowing
___ Increased pain at night

During the past month, have you often been bothered by feeling down, depressed or hopeless? YES or NO

Other Medical Conditions, Surgeries and Medications: (Please provide dosages for medication.)

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 Hertel and Brown Physical Therapy regardless of participation in or out-of-network. Should I default on my financial responsibility and collection is necessary, I will be responsible for collection costs that are incurred.

Patient/Parent/Guardian Signature: _____ Date: _____

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/Guardian Signature: _____ Date: _____