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

Primary Phone: _____(Cell/Home/Work) **Secondary Phone:** _____(Cell/Home/Work) **SS#:** _____

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

E-mail Address: _____

Occupation/Employer:_____ **Health Insurance Co.:** _____

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

Is this injury related to a motor vehicle accident? Y or **N** **Is this injury related to a workers compensation claim? Y** or **N**

Have you had surgery related to this physical therapy referral? Y or N Date of surgery:_____ /_____ /_____

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

Have you recently received home health? Y or N If yes, ending date and agency name:_____

Are you currently receiving treatment from a chiropractor or massage therapist? Y or **N** **Last treatment date:** _____ /_____ /_____

Marital Status: _____ **Emergency Contact:** _____ **Phone:** _____

Referring DR: _____ **Primary DR:** _____

Insurance Policy Holder: _____ **DOB**: _____ **Employer:** _____

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

How did you hear about us? _____

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.

X **Patient or 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.

X **Patient or Parent/Guardian Signature:** _____ **Date**: _____