Please **print** all information in the space provided.

Last Name ______________________________ First Name __________________________ M.I. _____

Social Security Number ______________________________ Date of Birth _______________________

Home Address ____

Home Phone (_____)_____________________________ Work/Cell Phone (____)__________________

E-Mail ____

Employer Name and Address ____

Emergency Contact _________________________________ Phone # ___________________________

I hereby authorize payment of medical benefits billed to my insurance to Bristol County Physical Therapy. I accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I understand that it is my responsibility to know the terms and coverage of my insurance plan. I authorize Bristol County Physical Therapy to release medical information to my insurance carrier to determine benefits payable.

I agree to pay all co-payments, co-insurance, and/or deductibles at the time the service is rendered.

____ Date ________________________
Signature of patient or Guardian

Health Insurance Portability and Accountability Act

_____ I have received a copy of HIPAA

_____ I have declined a copy of HIPAA

____ _______________
Patient Signature Date

BRISTOL COUNTY PHYSICAL THERAPY AND SPORTS REHABILITATION, LLC
PATIENT MEDICAL HISTORY FORM

Name:____ DOB:_____________________________

To help us better evaluate your condition please complete this form to the best of your knowledge. If you have any questions please ask for assistance. Thank you.

Past Medical History: (please mark any condition for which you have received treatment. Items not mark are understood to be negative.)

□ High Blood Pressure	□ Abnormal Bleeding	□ Bowel or Bladder Problems
□ Heart Problem	□ Asthma/Emphysema	□ AIDS/HIV Positive
□ Abnormal Heart Rate	□ Photosensitive	□ Recent Weight Loss/Gain
□ Pacemaker	□ Chronic Lung Problem	□ Thyroid Problem (Hyper or Hypo)
□ Heart Attack	□ Chronic Heartburn	□ Diabetes/Sugar (medication dependent)
□ Angina (chest pain)	□ History of Ulcers	□ Cancer (where? __________________)
□ High Cholesterol	□ Epilepsy/Seizures	□ Latex Sensitivity

Other: ____

Do you have a history of fractures?	□ YES	□ NO	Where? ______________________________
Do you have a history of back/neck pain?	□ YES	□ NO	When? ______________________________
Do you have any metal implants?	□ YES	□ NO	Where? ______________________________
Do you smoke?	□ YES	□ NO	How much per day? _____________________
Do you exercise regularly?	□ YES	□ NO	How often? __________________________
Do you have any known drug allergies?	□ YES	□ NO	Please list ___________________________
Are you pregnant or suspect pregnancy?	□ YES	□ NO	

Please rate your current pain: 0 1 2 3 4 5 6 7 8 9 10
none worse pain

In regards to your current condition:

Do you have any "pins and needles" or numbness in your extremities?	□ YES	□ NO
Do you have any weakness in your arms or legs?	□ YES	□ NO
Do you have any coordination or balance problems?	□ YES	□ NO
Do you have difficulty walking?	□ YES	□ NO
Do you experience dizziness or vertigo with a change in position?	□ YES	□ NO
Have you experienced headaches as a result of your condition?	□ YES	□ NO
Is anyone coming into your home and providing healthcare services?	□ YES	□ NO

Please list all current medications: ____
____

Please list all surgeries/date: ____
____

Please describe your symptoms: ____

Please check recent diagnostic tests performed: □ X-Ray □ MRI □ CT Scan □ Bone Scan □ Bone Density □ EMG □ Ultrasound

I believe all information to be true and complete: Signature:_________________________Date:_________

Physical Therapist Signature:______________________