PATIENT INFORMATON

Last Name_____ **First Name**_____**Middle**_____

Date of Birth _____ **Social Security #** _____**Email**_____

Address_____ **City** _____ **State**____ **Zip** _____

Home Phone _____ **Cell Phone** _____ **Appt Reminder Preference** __ **Call** __ **Text** __ **Email**

Employment Status;____ **Employed**_____ **Unemployed** _____**Self-Employed** ____**Student** ____ **Retired**

Employer_____ **Occupation** _____

Emergency Contact Name _____ **Phone Number**_____

Relationship to Patient ____**Spouse** ____**Mother**____ **Father**____ **Other**_____

Primary Care Physician_____ **Referring Physician**_____

How did you hear about our office_____

Personal Health Insurance _____ **SEE COPY OF INSURANCE CARD**___

Name of Subscriber _____**Patient Relationship to Subscriber** _____**Date of Birth** _____
ID # _____ **Group #** _____

POLICIES

If the following therapies are applicable to my treatments (to be discussed individually with therapist)

I give permission to Bodywise Physical Therapy, LLC to perform dry needling therapy.
I give permission to Bodywise Physical Therapy ,LLC to perform manipulation therapy
I give permission to Bodywise Physical Therapy, LLC to perform laser therapy.

Patient Name _____ **Date** _____

Patient/Guardian/Responsible Party Signature_____

I give permission to Bodywise Physical Therapy LLC to render treatment as needed.
I give permission to Bodywise Physical Therapy LLC to release my records to my physician / insurance or W/C.
I give permission to Bodywise Physical Therapy LLC to obtain records from my Physician for this case.
I acknowledge that Bodywise Physical Therapy LLC will bill my insurance company for services provided to me.
I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any copayments, coinsurance / deductible ,or charges not covered by insurance.
I understand that there is a fee for returned checks.
I have received a copy of the Bill of Rights & Privacy Notice

Patient Name _____**Date**_____

Patient / Guardian/ Responsible Party Signature _____

What is the reason for your visit today?_____

When did your symptoms start? _____ Date of next Doctor's appointment: _____

Have you had any diagnostic testing? ☐ X-ray ☐ MRI ☐ EMG / Nerve Conduction Test Other: _____

Who is your referring Doctor? _____

Did you have Surgery? ☐ Yes ☐ NO Date of surgery: _____

CURRENT COMPLAINTS

If you pain what is your pain level? 0= No Pain 10= Extreme Pain

At Worst 

Are your Symptoms: ☐ Constant ☐ Come and Go ☐ Ache ☐ Deep ☐ Superficial ☐ Dull ☐ Sharp ☐ Burning ☐ Tingling

Medications

☐ SEE COPY (We can copy your List) Name ,Dosage and Frequency including over the counter, prescription, herbal, vitamins

Previous Medical History / Medical Precautions and Contraindications

How would you classify your general health ☐ Good ☐ Fair ☐ Poor In terms of your general health, please check

All that apply:

• Allergies	☐ Heart Disease	☐ Fibromyalgia	☐ Night Pain
• High/Low Blood Pressure	☐ Heart Attack	☐ Rheumatoid Arthritis	☐ Hypoglycemia
• Pregnancy (only if currently)	☐ Stroke / TIA	☐ Osteoarthritis	☐ Seizures
• Metal Implants	☐ Pacemaker	☐ Hernia	☐ Depression
• Chronic Headaches	☐ Pain with Cough/Sneeze	☐ Asthma	☐ Night Pain
• Cancer	☐ Diabetes I or II	☐ Recent Fracture	☐ Surgeries

Is there any other information regarding your health or medical history that may complicate your ability to participate in therapy that we should know about ? _____

Have you had any falls in the past 12 month? ☐ Yes ☐ No If yes please describe injury _____Date _____

Patients Goal for Therapy

What are your goals for participating in Therapy? (IE *performing household tasks without pain*)

_____

_____

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