Silk Physical Therapy Center

Welcome

Thank you for entrusting your physical therapy care to us. Our goal is to help you attain your goals which should include relief of pain and improved physical functioning.

1 About You

Today's Date: _____

Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

First _____ MI _____

Last _____

Prefer To Be Called: _____

☐ Male ☐ Female

BirthDate: _____/_____/_____ Age: _____

SS #: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address: _____

City/State/Zip: _____

Home Phone #: (_____)_____

Work Phone #: (_____)_____Ext. _____

Pager/Other #: _____

Occupation: _____

Employer: _____

Employer's Address: _____

City/State/Zip: _____

Whom May We Thank For Referring You? _____

2 Insurance Coverage

FILL IN OR HAVE US PHOTOCOPY YOUR CARDS

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: : (_____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____

Relation: _____

Insured's BirthDate: _____/_____/_____

Insured's SS #: _____

Insured's Employer: _____

Do you have a secondary insurer? ☐ Yes ☐ No

! Nearest Relative

Please list the name of the nearest relative not living with you that we should contact in the event of an emergency.

His/Her Name: _____

Relation: _____

Address: _____

Home Phone: (_____)_____

Work Phone: (_____)_____

3 Account Information

Local Address (If different than permanent address):

_____

City/State/Zip: _____

Home Phone #: (_____)_____

Work Phone #: (_____)_____Ext. _____

Over

4 Medical History

Referring Physician's Name: _____

Your Current Physical Health is: ☐ Good ☐ Fair ☐ Poor

Are You Currently under the Care of a Physician? ☐Yes ☐ No

Please Explain: _____

Are You Currently on any Medication? ☐Yes ☐ No

If Yes, List Medications _____

_____

_____

Reason for Attending Therapy: _____

_____

_____

Location of Problem: _____

_____

Date of Onset: _____

Please List Any Medical Condition(s) That You Have Ever Had:

_____

_____

_____

_____

Please List All Allergies:

_____

_____

_____

_____

4 Medical History *continued*

Have you ever had any of the following diseases or medical problems?

Abnormal Bleeding	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Artificial Bones/Joints/Valves	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Cancer/Chemotherapy	☐ Yes	☐ No
Colitis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Difficulty Breathing	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No
Frequent Headaches	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Hospitalized for any Reason	☐ Yes	☐ No
Hormonal Changes	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Psychiatric Problems	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Shingles	☐ Yes	☐ No
Sinus Problems	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No

5 Signature

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Payment is due in full at the time of treatment unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.*

Signature _____ Date _____

*My signature requests that payment to be made and authorizes release of medical information necessary to pay the claim.