HAMILTON PHYSICAL THERAPY PATIENT DATA SHEET				
First:	MI:	Last:		
Date of Birth:	Age:	Gender: Male Female		
Physical Address:		Mailing Address:		
Phone Numbers: 0	OK To Call Best	t Time To Call		
Home:				
Work:				
Cell:				
May we send you text mes above? Yes No	sages for your a	appointment reminders to the number(s) listed		
May we send you text mes the number(s) listed above	<u> </u>	eting Materials, including Patient review requests to		
By marking "Yes" above, of unauthorized access to		that text messages may NOT be secure, with a risk		
<i>5</i> .	ddress below, yo	are with us? Yes No ou understand that email communications orized access to your information.		
Preferred language:		Interpreter required? Yes		
Date of Injury:	R	eferring Physician:		
Injury Area:		or Work Accident: Auto Work N/A		
State Where Accident Occ	:ured:	<u> </u>		
	•	eived Home Health Services Yes No No dressing, etc) in the last 60 days?		
Are you currently receiving the last 60 days?	ງ or have you rec	eived other therapy services in Yes No		
Marital Status:				
Married Single	Divorced [Widowed Separated Unknown		
Student Status:				
Full-Time Part-T	ime None			

EMPLOYM	ENT STATUS				
Employment Status: Active Military Full-Time None	Part-Time Retired Self Employed				
Employer:	Occupation:				
Address:					
Phone:					
Employer: C	Occupation:				
Address:					
Phone:					
INSURANCE INFORMATION					
Primary Insurance:					
Policy Holder's Name:	Holder's Birth Date:				
Policy or Certificate #:	Group #:				
Policy Holder's Employer:					
Secondary Insurance:					
Policy Holder's Name:	Holder's Birth Date:				
Policy or Certificate #:	Group #:				
Policy Holder's Employer:					

MR #: Page: 3/4 Patient Name: How did you hear about us? **Physician** Hospital Marketing Ad - Print **Employer Cross Referral** Friend - Word of Mouth Case Manager ■ Marketing Ad - Billboard Former Patient Marketing Ad - Direct Mail - Email Attorney Adjustor Self School **Screens - Open Houses** Marketing Ad - Other ____ Specify if other: Note: Please provide us with the most updated information below. **EMERGENCY AND OTHER CONTACTS** Name Phone Work Cell Fax Туре DISCLOSURE OF MEDICAL RECORDS I authorize the following individuals to have access to my medical and billing records: Relationship Name Relationship Name

Signature of Patient

Date

PATIENT INTAKE AND CONSENT FORM

A/C# Name A/C Type Office # Internal Use Only: CONSENT TO TREATMENT I consent to rehabilitation and related services at: HAMILTON PHYSICAL THERAPY In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. Initials: TREATMENT OF MINORS I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. Initials: LIABILITY I know and agree that: HAMILTON PHYSICAL THERAPY is not responsible for loss or damage to personal valuables. Initials: **WAIVER AND RELEASE** I hereby release, discharge and acquit: HAMILTON PHYSICAL THERAPY its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. Initials: **AUTHORIZATION OF PAYMENT** I hereby assign all benefits directly to: HAMILTON PHYSICAL THERAPY I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. Initials: FINANCIAL POLICY I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. To assist in establishing your account, please: - Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information. - Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered. - Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf. Initials: NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS I acknowledge receipt of Notice of Privacy Practices. Initials: I acknowledge receipt of the Statement of Patient Rights. Initials: I certify that all of the information provided herein is true and correct. Patient/Guardian Witness Signature Signature _

Medical History Form

Patient Name:	Today's Date:				
Referring Physician:	Date of Birth:	Age:			
Primary Care Physician:	Are You Presentl	Are You Presently Working?			
Date of Next Physician Appointment:	Date of Injury or	Date of Injury or Onset:			
Reason for Therapy:					
Cause of Injury or Onset: Accident Auto Work Other: If Other, please explain:					
Cause of injury of Officer Accident Auto Work Officer. If Officer, please explain.					
Have you been hospitalized for the present condition? Yes No If Yes, date:					
Did you have surgery for this condition? ☐ Yes ☐ No If Yes, date: If Yes, surgery type:					
Are you currently receiving any other care for the condition mentioned above? Yes No					
If Yes, please describe:					
Have you ever received therapy in the past for the condition mentioned above? Yes No If Yes, date: Describe previous treatment:					
Previous Treatment: ☐Successful ☐Unsuccessful Have you fallen in the last year? ☐ Yes ☐ No If Yes, how many times? If Yes, were you injured? ☐ Yes ☐ No					
Do you feel unsteady when standing or walking?					
What are your personal goals/outcomes you hope to achieve from therapy?					
Describe your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Do you smoke or use tobacco? ☐ Yes ☐ No					
DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)					
☐ Allergies ☐ Latex ☐ Other	☐ Dizziness	☐ Kidney Problems			
☐ Anemia	☐ Epilepsy or Seizure Disorder	☐ Metal Implants			
☐ Anxiety or Panic Disorders	☐ Fainting	☐ MRSA			
☐ Arthritis ☐ OA ☐ RA	☐ Fatigue or Weakness	☐ Multiple Sclerosis			
☐ Asthma	☐ Fever or Chills	☐ Nausea / Vomiting			
☐ Blood Thinners	☐ Fractures	☐ Osteoporosis			
☐ Bowel or Bladder Disorder	☐ Headaches	☐ Pacemaker			
☐ Bleeding Disorder	☐ Head Injury or Concussion	☐ Parkinson's Disease			
☐ Cancer	☐ Hearing Impairment	☐ Peripheral Vascular Disease			
☐ Chronic Cough	☐ Heart Disease or Heart Attack	☐ Respiratory or Breathing Problems			
☐ COPD	☐ Hepatitis ☐ A ☐ B ☐ C	☐ Ringing in Ears			
☐ Congestive Heart Failure	☐ Hernia	☐ Sexual Dysfunction			
☐ Currently Pregnant	☐ Blood Pressure ☐ High ☐ Low	☐ Skin Abnormalities			
☐ Deep Vein Thrombosis (DVT)	☐ HIV or AIDS	☐ Stroke or TIA			
☐ Depression	☐ Hypoglycemia	☐ Thyroid Problems			
☐ Diabetes ☐Type I ☐ Type II	☐ Hypersensitivity to Hot or Cold	☐ Tuberculosis			
List any other medical problems and explain:					
Over the Counter Medications (check all that apply): Aspirin/Ibuprofen Antacids Sleeping Aids Cold Medicine: Cough Medicine Allergy Relief Laxative Diet Pills Vitamins/Herbal Supplements Other:					

Medical History Form

Oral Other Other Oral Other Oral Oral Other	
Other Oral Oral Oral Other	
Oral Other Oral Other	
Other	
Oral	
Other	
Oral Other	
☐ Oral ☐Other	
☐ Oral ☐Other	
☐ Oral ☐Other	
Oral	
Oral Other	
☐ Oral ☐ Other	
Other Other	
 WNL {BMI = ≥ 18.5 and < 25 Above Normal Parameters [BMI ≥ 25 	
5]	
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