Date: ______________________________

DEMOGRAPHICS

Name: ____ Sex: ☐ Male ☐ Female
Last First Middle Initial

Birthdate: ______________________ SS#: ______________________

Marital Status: ☐Single ☐ Married ☐ Divorced ☐ Widowed ☐ Student

Home Address: ____
City St Zip

Please check which phone number is primary:

☐ Home #: ______________ ☐ Cell #: ______________ ☐ Work #: ______________

Email Address: ____

Employer: ______________________ Occupation: ______________________

How did you hear about us: ____

If under the age of 19 please list parent or legal guardian information:

Please check one: ☐ Mother ☐ Father ☐ Guardian

Name: ____

Home Address: ____
City St Zip

Home #: ______________ Cell #: ______________ Work #: ______________

EMERGENCY CONTACT INFORMATION

Emergency Contact: ____

Relationship to Pt: ______________________ Phone #: ______________________

INSURANCE INFORMATION

☐ Private Insurance ☐ Work Comp ☐ Auto Accident ☐ Self Pay ☐ Other __________

Primary Insurance: ____

Policy Holder: ______________________ Policy Holder DOB: ______________

Secondary Insurance *(if applicable)*: ____

Policy Holder: ______________________ Policy Holder DOB: ______________

AUTHORIZATION AND RELEASE

I certify that the information provided above is true and correct to the best of my knowledge. I authorize Platte Valley Physical Therapy, LLC, to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the physical therapist's office, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I understand I am responsible for all copays, deductibles, co-insurance, and balances. I personally agree to pay for any and all services provided to me at the rates in effect during the time services are rendered. I understand and agree that my bill for services rendered is due and payable at the time of service and that I am ultimately responsible for any unpaid balances.

Signature ______________________ Date ______________________

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, & HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Platte Valley Physical Therapy, LLC, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Platte Valley Physical Therapy, LLC, I understand that treatment of me by Platte Valley Physical Therapy, LLC, may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" (PHI) means health information, (including my demographic information) collected from me, or received from my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical / mental health, or conditions and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Platte Valley Physical Therapy, LLC, is not required to agree to the restrictions that I may request. However, if Platte Valley Physical Therapy, LLC, agrees to a restriction that I request, the restriction is binding on Platte Valley Physical Therapy, LLC, and all of its employees.

I have the right to revoke this consent, in writing, at any time, except to the extent that Platte Valley Physical Therapy, LLC, or its therapists has taken action based on this consent.

Platte Valley Physical Therapy, LLC's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Platte Valley Physical Therapy, LLC. The Notice of Privacy Practices for Platte Valley Physical Therapy, LLC, is posted in the waiting area. This Notice of Privacy Practices also describes my rights and the duties of Platte Valley Physical Therapy, LLC, with respect to my protected health information.

Platte Valley Physical Therapy, LLC, reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy to be sent in the mail, or asking for one at the time of my next appointment. This authorization is deemed good for one year after the date signed below.

Signature ______________________ Date ______________________

PERSONAL HEALTH HISTORY

Patient Name: ______________________________ Height: __________ Weight: __________

Referring Doctor: ______________________________ Primary Doctor: ______________________________

What are we seeing you for today: ______________________________

How did injury/condition occur: ______________________________

Injury occurred at (check one): ☐ Home ☐ Work ☐ School ☐ Sporting Event

☐ Church ☐ Gym ☐ Other ______________________________

Date of injury: ____________________ *OR* When did you first notice symptoms: ____________________

Did you have emergency room treatment for your current injury/condition: ☐ Yes ☐ No

Have you had x-rays or an MRI taken due to current condition? ☐ Yes ☐ No

Do you smoke: ☐ Yes ☐ No If "yes", how many packs per day: ____________________

Do you have any allergies: ☐ Yes ☐ No

If "yes", indicate what you are allergic to and reaction:

____

____

Do you have, or have you had: (please check if yes)

☐ Arthritis	☐ Osteoarthritis	☐ Rheumatoid Arthritis	☐ Osteoporosis
☐ Kidney Disease	☐ Liver Disease	☐ Epilepsy	☐ Rheumatic Fever
☐ Cancer	☐ Diabetes	☐ Stomach Ulcers	☐ Cortisone Drug
☐ Heart Disease	☐ High Blood Pressure	☐ Angina/Chest Pain	☐ Anemia
☐ Stroke/TIA	☐ Depression	☐ Polio	☐ Tuberculosis
☐ Chronic Bronchitis	☐ Asthma	☐ COPD/Emphysema	☐ Diabetic Ulcer
☐ Peripheral Neuropathy	☐ Peripheral Artery Disease	☐ Other ____________________	

Significant Past Medical History (Surgeries/Fractures): Year

______________________________ ____________

______________________________ ____________

______________________________ ____________

______________________________ ____________

______________________________ ____________

MEDICATIONS

What medications are you taking now? (Include prescription, over-the-counter drugs, supplements such as vitamins and herbals)

Medication Name	Dosage	Frequency	Oral	Injection	Other
______	______	______	☐	☐	☐
______	______	______	☐	☐	☐
______	______	______	☐	☐	☐
______	______	______	☐	☐	☐
______	______	______	☐	☐	☐
______	______	______	☐	☐	☐
______	______	______	☐	☐	☐
______	______	______	☐	☐	☐
______	______	______	☐	☐	☐

Have you fallen in the last year: ☐ Yes ☐ No

If "yes", how many times in the last year: ______

If you have fallen in the last year, were you injured: ☐ Yes ☐ No

If "yes", please explain: ______

______

______

PAIN SCALE

Please circle the level of pain you are currently having:

1	2	3	4	5	6	7	8	9	10
(None)									(Extreme)