



# DENTON SPORTS & PHYSICAL THERAPY CENTER

The leader in keeping you active & strong since 1984



PATIENT INFORMATION			
Patient's Last Name	First	Middle	How would you like to be addressed?
Street Address		City	State Zip Code
Home Phone	Work Phone	Cell Phone	Social Security Number (billing purposes)
E-mail Address		Date of Birth	Age Sex Male Female
Occupation	Employer	Employer Address	
Prescribing Physician's Name	Date of Last Physician Appt. / /	Date of Next Physician Appt. / /	How did you hear about our office?

INSURANCE / FINANCIAL INFORMATION			
Type of Insurance		Subscriber's Name	
Person Responsible for Bill		Responsible Party Address	
Phone Number	Student Status Full-time / Part-time	Accident Status None / Auto / Work / Other:	Date of Injury
Workers' Compensation Claim # (If Applicable)		Claim's Adjuster	Adjuster's Phone Number

IN CASE OF EMERGENCY			
Contact Name	Relationship to Patient	Home Phone	Work Phone

### DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Can you perform your daily activities? Yes No (Describe)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

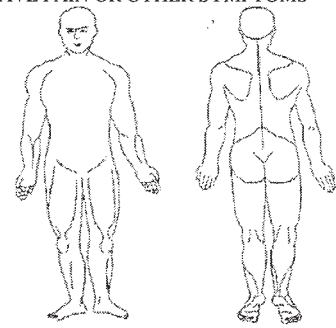
Have you ever had physical therapy for this condition? Yes No Year:

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



### HAVE YOU RECENTLY NOTICED?

Yes No Weight Loss/Gain	Yes No Weakness	Yes No Dizziness
Yes No Nausea/Vomiting	Yes No Fever/Chills/Sweats	Yes No Bladder/Bowel Changes
Yes No Fatigue	Yes No Numbness or Tingling	Yes No Chest Pain



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### HAVE YOU EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS?

Yes No Heart Problems	Yes No Hearing Loss/Disorder	Yes No Cancer
Yes No High Blood Pressure	Yes No Eye Disease	Yes No Osteoporosis
Yes No Circulation Problems	Yes No Muscular Disease/Disorder	Yes No Depression
Yes No Rheumatoid Arthritis	Yes No Multiple Sclerosis	Yes No Past Pregnancy
Yes No Other Arthritic Conditions	Yes No Tuberculosis	Yes No Current Pregnancy
Yes No Stroke	Yes No Epilepsy/Seizures	Yes No Chemical Dependency
Yes No Lung Disease	Yes No Hepatitis	Yes No Ulcers
Yes No Asthma	Yes No Kidney Disease	Yes No Other: _____
Yes No Pacemaker	Yes No Thyroid Problems	_____
Yes No Diabetes	Yes No Implanted Devices	_____

### LIST SURGERIES, MEDICAL CONDITIONS OR INJURIES FOR WHICH YOU HAVE BEEN TREATED

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

### LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (PILLS, INJECTIONS, INHALERS, ETC.)

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The above information is true to the best of my knowledge. I hereby authorize Denton Sports & Physical Therapy Center, to release any and all information concerning my care to my insurance company. I further authorize payment directly to Denton Sports & Physical Therapy Center, and I understand that I am financially responsible for all charges not covered by my insurance payments.

X \_\_\_\_\_ DATE

PATIENT/GUARDIAN SIGNATURE

### HIPPA Privacy Practices Acknowledgement See attached notice on clipboard

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_