Date:

BODY EASE
PHYSICAL THERAPY

Please complete ALL information to the best of your ability. All information we collect will be kept confidential and will only be shared with your physicians, insurance, &/or attorney per your authorization or court order.

Patient Name: _____

(last) (first) (MI) (nickname)

Social Security #:_____ Sex: M/F Marital Status: ☐ M ☐ S ☐ D ☐ W

Mailing Address: _____ Date of Birth: _____

City: _____State: _____ Zip: _____ Age: _____

Home Phone #: _____ Work #: _____

Cell Phone #: _____ Text reminder of appointment? ☐ Yes ☐ No

Email: _____ Email reminder of appointment? ☐ Yes ☐ No

Employer Name _____ Occupation: _____

Employer Address: _____

Referring Physician: _____ Practice Name: _____

*Parent/Guardian* (Please circle)

Name _____ Contact #: _____

Private Insurance Company: _____ Policy ID: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Secondary Insurance Company: _____ Policy ID: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Worker's Comp Ins: _____ Claim #: _____

Address, Phone #, Fax # (if you have it): _____

_____

Date of Injury: _____ Case Manager's Name: _____ Ph#: _____

Attorney's name, address, & Ph#: _____

Emergency Contact/Relation: _____ Phone #: _____

Are you receiving or have you received home health services? ☐ Yes ☐ No

Are you receiving or have you received other therapy services? ☐ Yes ☐ No

Date:

BODY EASE
PHYSICAL THERAPY

How did your pain start? Was it an injury or did it just come on gradually for no particular reason? If it was due to injury, please explain in detail. _____

_____

_____

Have you had anything like this before? _____

If this is a chronic problem, what usually brings it on? _____

Just prior to this onset, were you free of symptoms? ☐ Yes ☐ No

What, if any, treatments have you had for this problem? _____

Did the above treatment help? _____

Please provide a complete list of all current medications and supplements including: Name, Dosage, Frequency and Route. Please use back page if needed. _____

_____

_____

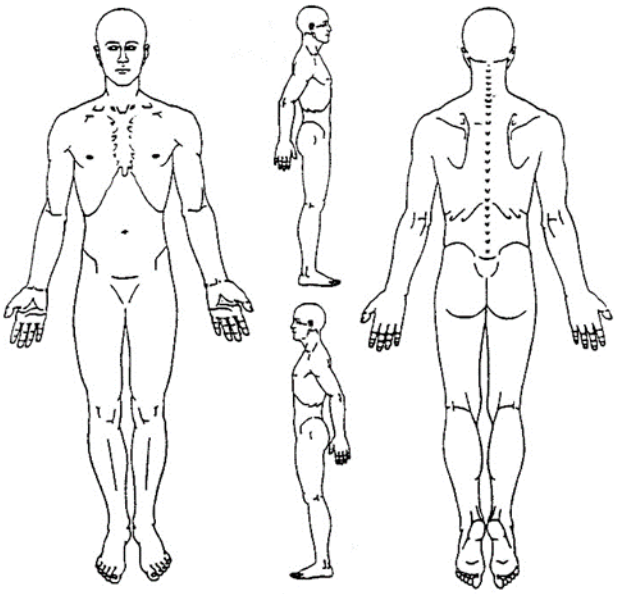
Have you had any falls recently? ☐ Yes ☐ No

If yes, describe: _____

Height: _____

Weight: _____

Please shade all areas of pain or numbness.



**Intensity:** On a scale of 0 to 10 (0 being no pain and 10 being severe), circle number that best describes pain.

At Best: 0 1 2 3 4 5 6 7 8 9 10

At Worst: 0 1 2 3 4 5 6 7 8 9 10

Current: 0 1 2 3 4 5 6 7 8 9 10

Date:

BODY EASE
PHYSICAL THERAPY

Describe pain: Sharp Dull Ache Burn Tingle Numb

Pain is made worse by: Sitting Lying Prolonged standing Bending Stairs
When first arising As the day goes on Other _____

Pain is made better by: Sitting Lying Prolonged standing Bending Stairs
When first arising As the day goes on Other _____

List any surgeries with dates you have had. Use back page if needed. _____

_____

_____

Serious illnesses or conditions: _____

When? _____

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**Consent for Treatment**

I hereby consent to evaluation and treatment by Body Ease Physical Therapy Centre as ordered by my physician(s). I authorize the release of information related to my treatment to my physician(s).

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself, not between my insurance company and this office. I authorize my health insurance company to make payment directly to Body Ease Physical Therapy Centre for any physical therapy services I receive. I am aware that benefits provided by my insurance are NOT a guarantee of payment and that I AM ULTIMATELY RESPONSIBLE FOR ALL CHARGES INCURRED DURING TREATMENT. All bills are considered the responsibility of the patient or guardian, and payments are due the day of service unless other arrangements have been made. Accounts beyond 90 delinquency will be sent to collections and any collection costs or attorney fees incurred will be the responsibility of the patient/guarantor.

I authorize the release of any information relating to my treatment in order to process my insurance claims and facilitate payment of my account.

- □ I acknowledge receipt or have been offered a copy of the Privacy Practices from Body Ease Physical Therapy Centre.

I have read and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____Date: ____/____/_____

Witness Signature: _____Date: ____/____/_____