EVOLVE
PHYSICAL THERAPY

To provide you with the best possible service, please provide the following information.

Patient Information

Name: _____ Date of Birth: _____/_____/_____ ☐Female ☐Male

Address: _____ City: _____ State:_____ Zip: _____

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____ Email: _____@_____

Employer:_____ Work Phone: (____) _____-_____

Emergency Contact:_____ Relationship: _____ Phone: (____) _____-_____

Primary Care Physician:_____ Phone: (____) _____-_____

Who may we thank for referring you or how did you hear about us? _____

Insurance Information

Policyholder Name: _____ Date of Birth: ____/____/_____ Relationship: ☐ Self ☐ Spouse ☐ Parent

☐ *Check to skip this section if insurance card was presented to front office staff*

Primary Insurance: _____ Policy/ID #: _____ Group #: _____

Insurance Address: _____ Insurance Phone Number: (____) _____-_____

Please inform us if you have secondary insurance

Parental / Guardian Information *(only for patients under the age of 18)*

Name of Persons Responsible for Account: _____ Date of Birth:____/____/_____

☐ *Check if address is the same as patient's address, otherwise please provide the following:*

Address: _____ City: _____ State:_____ Zip: _____

Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Other_____ Employer: _____

Work Phone: (____) _____-_____ Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____

Work Injury / Vehicle Accident Information

Accident / Injury Date: ____/____/_____ Claim Number: _____

Employer Address (If Applicable): _____ City: _____ State:_____ Zip: _____

Responsible Insurance Company: _____

Adjuster Name: _____ Adjuster Phone: (____) _____-_____

Current Injury / Problem: _____

What are your LOWEST and HIGHEST pain levels? *(please circle two)*

0 1 2 3 4 5 6 7 8 9 10

Have you ever been diagnosed with any type of the following conditions? (Check all that apply)

- ❏ Cancer (type) _____
- ❏ High blood pressure
- ❏ Heart disease
- ❏ Asthma
- ❏ Osteoporosis
- ❏ Pacemaker
- ❏ Anemia
- ❏ Stroke / CVA
- ❏ Depression
- ❏ Rheumatoid arthritis
- ❏ Chemical dependency
- ❏ Lung problems
- ❏ Thyroid: Hyper / Hypo
- ❏ Diabetes Type II / Type I
- ❏ Multiple sclerosis
- ❏ Kidney / liver disease
- ❏ Stomach ulcers
- ❏ Epilepsy
- ❏ Parkinsons
- ❏ Allergies
- ❏ Other_____

Have you recently experienced any of the following?

- ❏ Urinary or bowel problems
- ❏ Nausea / vomiting
- ❏ Dizziness / lightheadedness
- ❏ Difficulty maintaining balance
- ❏ Falls
- ❏ Difficulty swallowing
- ❏ Fever / chills / sweats
- ❏ Weight loss / gain
- ❏ Shortness of breath
- ❏ Headaches
- ❏ Changes in appetite
- ❏ Pain at night
- ❏ Weakness / fatigue
- ❏ Other _____

Current Medications,dosage & supplements: *(☐ copy of list provided)* _____

_____

Are you currently taking any blood thinning medications? ☐N ☐Y _____ **Do you smoke?** ☐N ☐Y PPD_____

Females: Are you currently pregnant or planning on becoming pregnant? ☐N ☐Y

Please list any prior surgeries or hospitalizations:

_____

_____

What clinical tests have you had relating to your current condition? ☐X-ray ☐MRI ☐CT-Scan ☐Bone Scan ☐Other

Location: _____

Please list the activities or positions that are most limiting due to your condition:

_____

_____

Consent for Care and Treatment:

I, the undersigned, do hereby agree and give my consent for Evolve Physical Therapy to furnish medical care and treatment to me (or my child) considered necessary and proper in diagnosing and/or treating my (or my child's) condition. I acknowledge that I have been offered a copy of Cancellation / No Show Policy and HIPAA Privacy Practices of Evolve Physical Therapy and agree to the terms therein.

X_____ ____/____/_____

Signature of Patient *(Parent if Patient is a Minor)* Date