NORTH IDAHO PHYSICAL THERAPY

PATIENT NAME ______________________________ MALE________ FEMALE_________

HOMEPHONE_______________________CELLPHONE_______________________EMAIL_______________________

ADDRESS ______________________________ CITY ______________________ STATE _____ ZIP _________

BIRTHDATE ______________ SS# ____________________ SINGLE_________ MARRIED ___________

PATIENT'S EMPLOYER ______________________________________ PHONE ___________________
(or name of school if patient is a student)

SPOUSE'S NAME ______________________________ SPOUSE'S EMPLOYER ________________________
(or name of parent patient resides with if patient is a minor and parent employer)

RESPONSIBLE PARTY (if different from patient)

NAME ____**BIRTHDATE**___________________

ADDRESS____ **PHONE#**_________________________

Name of relative or friend to contact for emergency:_________________________ phone:______________ relation:__________

Whom may we thank for referring you to North Idaho Physical Therapy? ______________________________

REFERRING PHYSICIAN ______________________________ FAMILY PHYSICIAN___________________

DATE OF LAST DR VISIT ____________________ DATE OF NEXT DR VISIT ________________________

WHAT CONDITION ARE WE TREATING YOU FOR: ____

IS THIS CONDITION THE RESULT OF AN INJURY OR ACCIDENT? **yes no**

If no injury involved, please continue to Health Insurance Information in Block 3

WHAT WAS THE DATE OF INJURY: ______________ **HOW WERE YOU INJURED:** ______________________

DID THE INJURY OCCUR AT WORK? yes no HAVE YOU FILED A CLAIM WITH YOUR EMPLOYER? yes no
(if you answered yes to this please complete blocks 1 and 3 below)

INJURY DUE TO AUTO ACCIDENT? yes no **(if yes, complete blocks 2 & 3 below)** STATE MVA OCCURRED _____________

1.) WORK COMP INSURANCE INFORMATION

Name of employer who work related claim is filed with ______________________________ phone ___________

Insurance Carrier for this work related claim ____

Claim Number for this claim ______________________________ Claim Adjuster ______________________

2.) AUTO INSURANCE INFORMATION - Have you filed this with your own auto insurance? yes no

Patient's Automobile Insurance ____phone#___________________

Policyholder Name ____ Claim # ________________________

Responsible Party's Insurance ______________________________ Policyholder name ____________________

3.)

HEALTH INSURANCE INFORMATION

BLUE SHIELD * BLUE CROSS * MEDICARE * MEDICAID * GROUP HEALTH * UHC * OTHER

Name of Insurance if not listed above: _________________________SUBSCRIBER NAME___________________

SUBSCRIBER DATE OF BIRTH: ____________________ RELATIONSHIP TO PATIENT ___________________

SUBSCRIBER ID# __________________________________GROUP # _______________________________

I AUTHORIZE MY INSURANCE COMPANY (OR ATTORNEY IF APPLICABLE) TO MAKE PAYMENT DIRECTLY TO NORTH IDAHO PHYSICAL THERAPY. I AUTHORIZE THE RELEASE OF INFORMATION NECESSARY TO PROCESS MY CLAIM AND I ACKNOWLEDGE I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES. I UNDERSTAND IT IS MY RESPONSIBILITY TO HAVE ANY PRECERTIFICATION IN PLACE IF SO REQUIRED BY MY INSURANCE. I ACCEPT FULL RESPONSIBILITY FOR THE CHARGES INCURRED.

CREDIT TERMS: BALANCES REMAINING UNPAID ON ACCOUNT AFTER THE 1ST DAY OF THE MONTH FOLLOWING THE MONTHLY BILLING STATEMENT DATE ARE SUBJECT TO FINANCE CHARGE AT THE PERIODIC RATE OF 1.5% PER MONTH, WHICH IS ANNUAL PERCENTAGE RATE OF 18%. WE COMPUTE THE FINANCE CHARGE BY APPLYING THE PERIODIC RATE TO THAT PORTION ON YOUR ACCOUNT WHICH IS OVER 90 DAYS. I HAVE BEEN OFFERED A COPY OF THE HIPAA & NOTICE OF PRIVACY POLICY.

____ ______________________________

PATIENT OR GUARDIAN SIGNATURE DATE

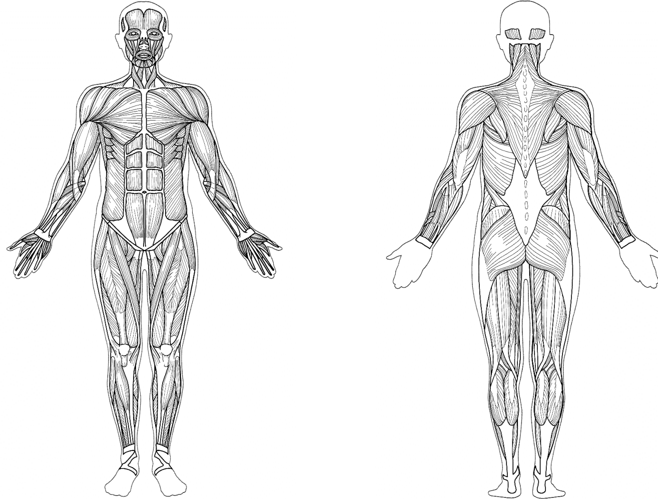
MEDICAL HISTORY

Name: ____ **Date:** _________________

Please indicate your pain level on the days below based on a scale of 0 to 10 with 0 being no pain and 10 being the worst pain imaginable:

Today ______ Best Day ______ Worst Day ______

Please indicate on the body diagram below the areas which you are having symptoms



Circle the word(s) that best describe your symptoms: aching, burning, stabbing, shooting pain, tightness, weakness, numbness, pins & needles, Other (please describe): _________________

____

Was there an accident or injury that caused your symptoms? ________ If yes, please indicate date and explain ____

What in particular makes your symptoms worse? ____________________________________

What, if anything, eases your symptoms? ____

Have you had Physical Therapy before? When, what for? ______________________________

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for North Idaho Physical Therapy to furnish medical care and treatment to (patient name) ________________________________ considered necessary and proper in diagnosing and treating his/her physical condition.

Patient / Guardian Signature: ______________________________ **Date:** ______________

Please complete other side >

Medical History (cont'd): Do you have, or have you had, any of the following? Please circle your answers and write any comments you feel are important.

			Comments
X-ray, MRI, or CT scan for this condition	No	Yes	
Joint Implants or Replacements	No	Yes	
Pacemaker, Heart Disease, or Heart Attack	No	Yes	
High Blood Pressure, Stroke	No	Yes	
Respiratory or Lung Disease (e.g. Emphysema, Tuberculosis, Asthma)	No	Yes	
Epilepsy, Convulsions	No	Yes	
Diabetes	No	Yes	
Tumor or Cancer (please explain)	No	Yes	
Hernia	No	Yes	
Hepatitis, Anemia, or other Blood Disorders	No	Yes	
Thyroid Disorders	No	Yes	
Do you smoke?	No	Yes	
Are you Pregnant?	No	Yes	

Please list other medical conditions that are related to what you are being seen for:

____

Please list previous operations, fractures, or serious injuries with approximate dates:

____

Please list any allergies (lotions, detergents, latex, adhesives, or medications):

____

Please list present medications and what they are for:

____