DAY ONE
PHYSICAL THERAPY & WELLNESS

First Name _____ Middle _____ Last _____

Circle One: Male/Female DOB _____ Email _____

ADDRESS _____ CITY _____ ST _____ ZIP CODE _____

Cell Phone _____ Home Phone _____

Emergency Contact _____ Relationship _____ Phone _____

Referring Doctor's Name _____ Phone _____

Last Seen by referring doctor ____/____/____ Next Dr Appt _____

Date of Injury_____ Date of Surgery (if applicable) _____

ARE YOU RECEIVING HEALTH CARE SERVICES OF ANY KIND IN YOUR HOME? ___ YES ___ NO

IS THERE AN ATTORNEY INVOLVED IN YOUR CASE/INJURY? ___ YES ___ NO

INSURANCE INFORMATION

PRIMARY _____

Name of Policy Holder _____ Policy Holder DOB _____

SECONDARY _____

Name of Policy Holder _____ Policy Holder DOB _____

CONSENT FORM/ASSIGNMENT OF BENEFITS/PRIVACY PRACTICES

INITIAL the following:

_____ I hereby agree and give my consent for Day One Physical Therapy & Wellness to provide physical therapy treatment. I authorize Day One Physical Therapy & Wellness to release and obtain all information necessary from my referring physician, other physician, insurance carriers, or third party payers. I hereby assign Day One all payments for services rendered to myself or my dependents and understand that I may be responsible for any uncovered charges.

_____ I have been notified of this office's ***Notice of Privacy Practices (HIPPA)***

Please give name(s) of relative, friend or other representative who may have access to your medical records:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature (Patient/Guardian): _____ Date: _____

DAY ONE
PHYSICAL THERAPY & WELLNESS

MEDICAL HISTORY

Have you ever had OR currently have any of the following conditions?

High Blood Pressure	Yes	No	Kidney/Liver Problems	Yes	No
Cardiac Conditions (Heart Attack or Pacemaker)	Yes	No	Vision Problems (Glaucoma or Cataracts)	Yes	No
Circulation Problems	Yes	No	Claustrophobia	Yes	No
Seizures	Yes	No	Dizzy Spells	Yes	No
Cholesterol	Yes	No	Diabetes	Yes	No
Allergies	Yes	No	Nervous Disorders	Yes	No
Fractures	Yes	No	Cancer	Yes	No
Arthritis/Osteoporosis	Yes	No	Metal Implants	Yes	No
Speech Problems	Yes	No	Sensitivity to heat/cold	Yes	No
Stroke	Yes	No	Pregnant	Yes	No

Surgeries _____

_____

Current Medications _____

_____

What are we seeing you for today? (circle all that apply)

Shoulder:	Right	Left	Bilateral	**Knee**:	Right	Left	Bilateral
Ankle/Foot:	Right	Left	Bilateral	**Hip**:	Right	Left	Bilateral
Neck:	Right	Left	Bilateral	**Back**:	Right	Left	Bilateral
Face/Head:	Right	Left	Bilateral	**Arm/Hand**:	Right	Left	Bilateral

Briefly describe the history/symptoms of your present illness or injury _____

_____

Where did your injury occur? Home Work School Motor Vehicle Accident

Other _____

Have you ever had physical therapy for your current condition? Yes No