

Medical History

Have you received **ANY** physical therapy in this current calendar year? Yes _____ No _____

Have you been treated here or by another physical therapist previously? Yes _____ No _____

If yes, where? _____ When? _____

Was it for the same condition? Yes _____ No _____ If not, please specify: _____

Date of onset of current episode of symptoms/injuries/illness: _____

Have you seen a physician for this condition? Yes _____ No _____ if yes, when? _____

Do you have a pacemaker? Yes _____ No _____

If you are having pain, is there anything that makes it feel better or worse? *Briefly explain:* _____

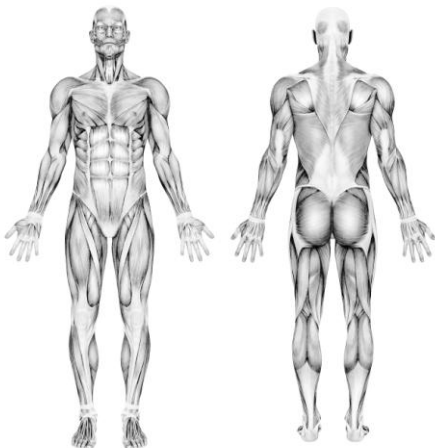
What kind of pain are you having? *Please an X in the box/boxes below:*

Aching	Numbness	Pins & Needles	Burning	Stabbing

How bad is your pain? *Please circle the number below:*

Low Pain			Moderate Pain				Maximal Pain		
1	2	3	4	5	6	7	8	9	10

Please mark the areas of pain on the diagram below:



Place of injury: Home _____

School _____

Work _____

Auto _____

Other _____

Responsibility Information

Who will be primarily responsible for the bill? _____

I will be paying my share of financial responsibility by: Cash ___ Check ___ Credit Card ___

PRIMARY Insurance Company: _____ Phone #: _____

Policy Holder's Name:

_____ last first middle

Policy Holder's Social Security #: _____ Date of Birth: _____

Address: _____
street city state zip

Policy Holder's Employer: _____ Position: _____

Is there Secondary Insurance? Yes ___ No ___

Name of Secondary Insurance Company: _____

IS THIS A WORKER'S COMPENSATION CLAIM? Yes ___ No ___ Date of Injury: _____

Company: _____ Address: _____

Phone Number: _____ Claim #: _____ Contact Person: _____

IS THIS AN ACCIDENT CASE? Yes ___ No ___ VEHICLE ___ OTHER _____

Insurance Company to Bill: _____

Address: _____
street city state zip

Phone #: _____ Claim #: _____

Adjuster Name: _____ Date of Accident: _____

Is there an attorney involved in your case? Yes ____ No ____

Attorney's Name: _____ Phone: _____

Address: _____
street city state zip

I hereby authorize Columbus Physical Therapy, P.C. to furnish information to the insurance carriers concerning my treatment and hereby assign to the therapist(s) all payments for service rendered. I understand that I am responsible for all charges, even those not paid by my insurance within 30 days of initial statement.

I understand that by signing I am giving my permission for treatment. I hereby authorize my referring physician to release any records necessary to secure payment of benefits to Columbus Physical Therapy, P.C.

I also authorize Columbus Physical Therapy, P.C. to contact the insurance commissioner on my behalf, to assist me in receiving my full insurance benefits, if deemed necessary.

SIGNATURE: _____ DATE: _____

Signature for Minor (under 18 years of age) _____

I have been provided with a brochure required by the Health Insurance Portability and Accountability Act (HIPAA) from Columbus Physical Therapy, P.C. This document explains how medical information about me may be used, disclosed and/or accessed.

Signature

Date

Office Use Only ITF:	PT:
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