Bainbridge Island Physical Therapy PATIENT INFORMATION

Patient Name (Full):____Date:________________

Address:_______________________________City:___________________________State:_______Zip:________

Best phone number to reach you during business hours: ____________________________________

Home Phone:_________________Cell Phone:__________________________Work Phone:_____________________

Birth date:_________________Email:____

Gender: ○M ○F Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated

Social Security #:_________________________Occupation:____

Referring M.D.:______________________________Primary Care M.D.:__________________________________

Emergency contact/relationship to you:__________________________________Phone:_______________________

FINANCIALLY RESPONSIBLE PERSON ☐Self

Insured:______________________________Relationship to you:__________________SSN:____________________

Address:_______________________________City:___________________________State:_______Zip:________

Home Phone:_________________Cell Phone:___________________________Birth Date:______________________

Are you seeking treatment for a condition related to a work or auto injury? ○Yes ○No

WORKMAN'S COMP or NO FAULT: Insurance Company and Billing Address:_________________________________

____

Employer:_____________________________Claim #:___________________Date of Injury: __________________

Claims Adjuster:____Phone:__________________________________

CONDITIONS OF TREATMENT and FINANCIAL POLICY *(Please read and sign)*

PATIENT RESPONSIBILITY: As a patient receiving medical care, I am aware of my insurance coverage and limitations. It is my responsibility to determine insurance benefits and provide Bainbridge Island Physical Therapy with correct billing information. I will assist with obtaining necessary pre-authorizations when needed as failure to obtain this may result in a reduction or rejection of benefits by the insurance company. I will be responsible for any deductible, co-payments or other patient balances due and payable upon receipt of a monthly statement. Payment options include cash or check. I understand that past due accounts may be assigned to an outside agency for collection. I have had an opportunity to ask questions and accept the responsibility of these terms.

CONFIDENTIALITY/RELEASE OF MEDICAL INFORMATION: Your medical history and personal information will be held in strict confidence. Your case will only be discussed or shared for purposes of necessary communication with your physician or to satisfy requirements for payment. A detailed copy of our Privacy Policy is available upon request.

ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL INFORMATION:
I hereby authorize payment of medical benefits to Bainbridge Island Physical Therapy for services rendered to my dependents or myself. I also authorize the release of any medical information that is necessary to process insurance claims. I understand that I am responsible for any amount not covered by insurance. This assignment will remain in effect until revoked by me in writing. *I certify that the information I provide is true and correct to the best of my knowledge. I give my permission to the practitioner to administer and perform such procedures as may be deemed necessary for treatment.*

Patient Signature:____Date:__________________

For persons under age 18-Parent signature:____Date:__________________

----- Please continue on the back -----

Bainbridge Island Physical Therapy HEALTH HISTORY FORM

Please speak directly with your Physical Therapist if you have any medical history issues that you wish not to list.

Name:____Age:_______Date:____________________

Date of last complete medical examination:______________Performed by:_______________________________

Are you currently receiving ANY form of Home Health Care? ○ Yes ○ No For?___________________________

Next scheduled Dr. appointment(s) Date:________________Physician:________________________________

When did your condition start: Give specific date of injury or onset of pain?_____________________________

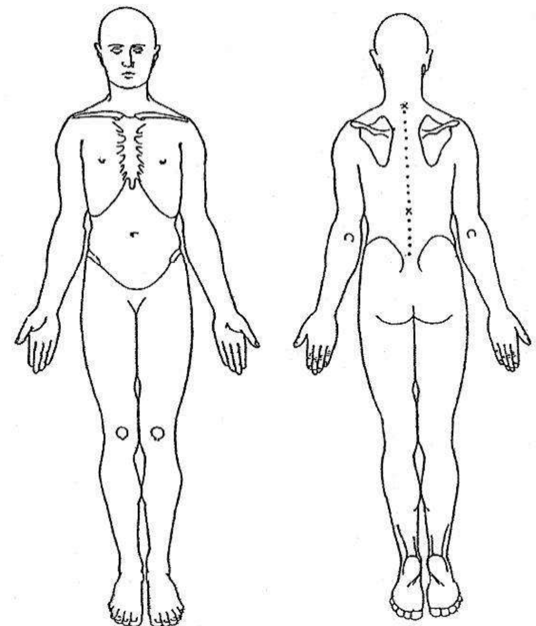
Did you have surgery? ○ Yes ○ No Surgery Date:____________Procedure:______________________________

Did you have the following tests? ☐ Xray ☐ MRI ☐ CT Scan ☐ EMG ☐ Other:___________________________

Have you been treated here or by another physical therapist before? ○ Yes ○ No Same condition? ○ Yes ○ No

Where?______________________When?__________________Who referred you to BIPT?____________________

Are you currently taking any medications? ○ Yes ○ No Please complete the attached Medication List.



Do you have Pain? If so draw on the Body Chart where your pain is located

What does your pain feel like? (check all that apply)

☐ Sharp ☐ Burning ☐ Aching ☐ Tingling ☐ Numbness

☐ Other____

Does pain radiate to arms or legs? ○ Yes ○ No

Does the pain keep you up at night? ○ Yes ○ No

Rate your PAIN: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

(0=none, 10=severe)

What makes your pain worse? (check all that apply)

☐ Lying down ☐ Sitting ☐ Standing ☐ Walking ☐ Other________________

What eases your pain? (check all that apply)

☐ Lying down ☐ Sitting ☐ Standing ☐ Walking ☐ Other________________

Recent weight loss or gain? ○ Yes ○ No Height_________ Weight_________BMI________

Exercise when injury free? ○ Yes ○ No Any other conditions we should be aware of?_____________________________

Are you pregnant? ○ Yes ○ No

Were you in a Motor Vehicle Accident? ○ Yes ○ No

Do you now or have had any of the following? (check all that apply)

☐ Heart Disease	☐ Diabetes	☐ Allergies	☐ High Blood Pressure	☐ Asthma
☐ Heart Attack	☐ Pacemaker	☐ Kidney Problems	☐ Headaches	☐ Thyroid Issues
☐ Cancer	☐ Infections Disease	☐ Hernia (any)	☐ Nervous Disorders	☐ Seizures
☐ Stroke	☐ Dizziness	☐ Shortness of Breath	☐ Previous Surgery	☐ Metal Implants

If yes to any of the above please give details and approximate dates:___________________________________

All statements above are true to the best of my knowledge____

PATIENT SIGNATURE and DATE

Bainbridge Island Physical Therapy MEDICATION LIST

Required for Medicare patients

Please include all prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements.

Patient Name (Full):____Date:_______________

Medication	**Dosage**	**Frequency**	**Route of administration (oral, injection, etc.)**