MEDICAL HISTORY & RELEASE OF INFORMATION

CURRENT MEDICAL INFORMATION

Patient Name (Last, First, MI):		**DOB:**
Referring Physician:	**Primary Physician:**	
Reason for Visit: ☐ New Illness / Pain / Injury	☐ Recurrent Illness / Injury	☐ Sports Injury
☐ On-the-Job Injury	☐ Motor Vehicle Accident	☐ Other:_____
Approximate Date of Onset: _____ /_____ /_____ (Month / Day / Year)	**Area(s) of body affected:**	
How did the injury occur?:	**Please rate the severity of your pain?** ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 (MILD … MODERATE … SEVERE)	
Have you been treated by a Home Health Agency within the last 12 months? ☐ Yes ☐ No **If yes, where?**		
Have you been treated by another Physical Therapy Clinic within the last 12 months? ☐ Yes ☐ No **If yes, where?**		
Have you had any tests relating to your injury? ☐ Yes ☐ No **Where were those done?**		

PAST MEDICAL HISTORY

Have you had any past surgeries? ☐Yes ☐No **If yes, please list below.**

Surgery	Date	Doctor

Do you have a latex allergy? ☐Yes ☐No

Do you have a history of (please check all that apply):

☐ Arthritis ☐ Asthma ☐ Cancer ☐ Diabetes ☐ Stroke
☐ Heart Disease ☐ HIV/Aids ☐ Blood clots ☐ Lung Disease ☐ Pacemaker
☐ Osteoporosis ☐ Frequent Falls ☐ Current Pregnancy

List any other Medical Conditions: _____

Patient Authorization for Use and Disclosure of Protected Health Infromation

By signing below, I hereby authorize Physical Therapy Associates, Inc. to receive, use or disclose protected health information about me to only the following people:

Name:	Relationship to Patient:

This authorization will expire on: ☐ Indefinitely ☐ _____ (Specify Date of Expiration)

- The practice will not receive payment from a third party for using or disclosing Personal Health Information.
- I may inspect or copy the PHI to be used or disclosed.
- When my information is used or disclosed pursuant to the authorization, it may be subject to re-disclosure by the recipient and no longer protected by the federal HIPPA Privacy Rule.
- I do not have to sign this authorization in order to receive treatment from Physical Therapy Associates. I have the right to refuse to sign this authorization.
- I have the right to revoke this authorization by submitting a written request to this office.

_____ _____ _____

Patient Signature **Parent/Guardian Signature** (Required if patient is under 18) **Date**