

# Jaworski Physical Therapy, Inc.

## Patient Medical History Form

Name:		SSN#	Phone:	
Email:		Would you like email reminder of your appointments? Yes or No	Cell Phone:	
Address:		City:	State	Zip Code
Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Employer:	Occupation:	
Cardholder (if different)		Relationship to cardholder		Date of Birth of Cardholder
Address:		City: State	State	Zip Code

Were you referred to this clinic by another medical provider?  Yes  No If yes: \_\_\_\_\_

Are you seeing anyone else for treatment of this same condition?  Yes  No

Have you ever had this condition in the past?  Yes  No

Did you receive treatment at that time?  Yes  No

Did that treatment help?  Yes  No

For Therapist Use Only
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Past History: Please check if you have or ever had one of these conditions or problems.

- |  |   |
|--|---|
| <input type="checkbox"/> Cancer                          | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Heart Problems                  | <input type="checkbox"/> Muscular disease     |
| <input type="checkbox"/> Circulation Problems            | <input type="checkbox"/> Lung Disease         |
| <input type="checkbox"/> High Blood Pressure             | <input type="checkbox"/> Arthritis            |
| <input type="checkbox"/> Nervous System Disease          | <input type="checkbox"/> Diabetes             |
| <input type="checkbox"/> Cardiac Pacemaker               | <input type="checkbox"/> Hepatitis            |
| <input type="checkbox"/> Metal implants (rods, pins etc) | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Joint Replacements              | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Bone Fracture                   | <input type="checkbox"/> Depression           |
| <input type="checkbox"/> Back Problem                    | <input type="checkbox"/> Neck Problem         |
| <input type="checkbox"/> Kidney Disease                  | <input type="checkbox"/> Other: _____         |

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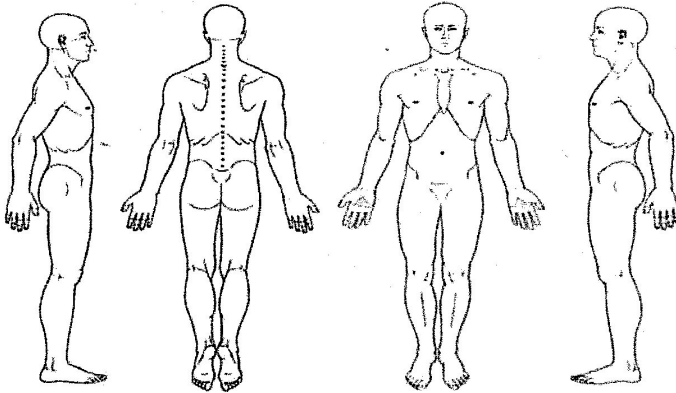
Are you or do you think you may be pregnant?  Yes  No

Please list any surgeries that you have had including date if known: \_\_\_\_\_

Please list any prescription or non prescription medications that you are currently taking: \_\_\_\_\_

Please briefly describe the problem(s) for which you are seeking treatment \_\_\_\_\_

When did this problem start? \_\_\_\_\_



Please mark on the picture anyplace that you are having pain, tingling or numbness

What is your current pain level?:

0 \_\_\_\_\_ 5 \_\_\_\_\_ 10  
No Pain Possible \_\_\_\_\_ Worst

Person to contact in case of an emergency: \_\_\_\_\_ Phone \_\_\_\_\_

**Consent to Release**

I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Jaworski Physical Therapy, Inc. ("The Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the regulations. I am aware that The Practice maintains a "Privacy Notice" which sets forth the types of uses and disclosures that The Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which The Practice will make such use or disclosure. *By signing this Consent, I understand and acknowledge that I have reviewed the "Privacy Notice" which is attached before signing this Consent.*

**General:** I hereby assign all medical benefits to include Major Medical, Medicare, Private Insurance and other sponsored programs and health plans and I authorize payment of medical benefits to Jaworski Physical Therapy, Inc. I understand that I am financially responsible for all charges whether or not paid by said insurance and I hereby authorize said assignee to release all information necessary to secure payment of said benefits. The assignment will remain in effect until revoked by me in writing.

**Authorization for Treatment:** I know that I am suffering from a condition(s) requiring physical/occupational/speech therapy. I hereby voluntarily consent to such treatment and procedures as prescribed by my physician and to be performed by employees of Jaworski Physical Therapy, Inc.

**Permission to take Photograph:** I hereby consent or deny Jaworski Physical Therapy, Inc. to take a photograph of me only for the purpose to use in my medical chart and will not be disclosed for any other reason without additional permission from me. I do so by checking yes or no below.

\_\_\_\_ YES \_\_\_\_ NO  
**Permission to take Photograph**

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Signature other than patient (if patient is a minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness