**SEPPIE** | PHYSICAL THERAPY, LLC

# Patient Information & Medical History

## Patient Information

**Today's Date:**

First Name: ______________________ Last Name: __________________________ Middle Initial_____

DOB: ___/___/___ Last 4 Digits of SSN:______ Sex: M F Marital Status:________ Name of Spouse:________________

Home Address:____________________ City:___________________ State:____ Zip:_____________

Billing Address:____________________ City:___________________ State:____ Zip:_____________

Home Phone: (____)_____-_______ Work Phone: (____)_____-_______ Cell Phone: (____)_____-_______

Email Address: _______________________________________ Preferred Method of Contact:______________________

Emergency Contact: __________________________________ Phone Number:(____)_____-_______

If a Minor Name of Responsible Party:______________________________ Relationship to Patient:_____________

Reason for today's visit:__________________________________ Date of Onset/Injury/Accident:_____/____/_____

Date of Surgery if applicable: _____/____/_____ Referring Physician:__________________________________________

## Insurance Information

**Primary Insurance:**

Name of Insurance:______________________ Phone Number: (____)_____-_______ Employer:_______________

Address of Insurance:_____________________________________ Policy Holder Name:_______________________

Relationship to Patient:____________________ Birthdate of *Policy Holder*: _____/____/_____

Policy #:___________________ Group #:_________________ **Please provide your insurance card to the front desk to be copied.**

**Secondary Insurance:**

Name of Insurance:______________________ Phone Number: (____)_____-_______ Employer:_______________

Address of Insurance:_____________________________________ Policy Holder Name:_______________________

Relationship to Patient:____________________ Birthdate of *Policy Holder*: _____/____/_____

Policy #:___________________ Group #:_________________

## Consent to treat and authorization to release information: Please Initial the Statements Below

___ I consent to evaluation and treatment by Seppie Physical Therapy, LLC and realize that I have the right to refuse any procedure after having the risks and benefits explained to me.

___ I authorize the release of information acquired in the course of my treatment, including but not limited to medical records, electronic media and oral communication, to my insurance company, primary care physician, referring physician, and/or third party payer.

___ I authorize phone, text, email messages regarding my treatment and appointments to be left with the persons or machines at the addresses/numbers above.

___ If I am unable to attend my scheduled appointment I must contact the clinic 24 hours in advance to cancel. If no notice is given your account will be charged $25.00 this fee will not be billed to your insurance it will be your responsibility. If you contact the staff or leave a voicemail afterhours we will waive the fee, or if the no-show is due to an emergency.

___ I acknowledge that I have received the opportunity to review the Notice of Privacy Practices of Seppie Physical Therapy, LLC and by signing this form I consent to allow Seppie Physical Therapy, LLC to use my personal health information for the treatment, payment and healthcare operations per their direction. I understand that I have the right to restrict how this information is disclosed per written request and may obtain a copy of the Notice of Privacy Practices. I request that insurance payments are made directly to Seppie Physical Therapy, LLC. I understand that this authorization may be used by the provider and its billing agent for any services provided to me in the past and in the future.

## Clinic Information and Policies:

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**Medical Records:** Please give our staff up to 48 hours to complete the copying of your records once an official signed Release of Protected Health Information has been completed. A fee may be applied for records received.

**Children:** For safety reasons we **do not allow children on any of the equipment**. Please supervise your children while in our facility and never leave them unattended.

**Cell Phones:** Please turn your cell phone off during your appointment; it creates a distraction to you, your therapist and other patients. If you have a need to use your phone or have an emergency, please let your therapist know.

**Financial Policy:**

**Financial Responsibility and Payments:** By accepting medical including but not limited to consultations, examinations and physical therapy, the undersigned patient/responsible party agrees to pay Seppie Physical Therapy, LLC all charges for such services or treatment. If Medicare, Medicaid, Workers Compensation, Champus or similar government program or legal judgment should determine that I am not eligible for coverage or that the service or treatment is not covered, I will be responsible for payment. ***Payment for services not covered by insurance are expected at the time of service.*** Accounts that become past due by 60 days will be assessed a finance charge. After 6 months any unpaid balance is subject to be sent to a collections agency. The patient or responsible party agrees to pay all cost of collection, including attorney's fees on the amount turned over to collections. Payment plans can be made upon request.

By signing below you acknowledge that you have read and understand the information on this form and are aware of the policies of Seppie Physical Therapy, LLC.

**Patient (Guardian) Signature:** ________________________________________ **Date:**____/____/____

***Staff Signature***: ________________________________________ **Date:** ____/____/____

## Health History and Family Medical History:

If you or a close family member has been diagnosed with the following please check and explain.

| Condition: | Self: | Family: | Relation to Patient: | Details: (Date of Diagnosis, type, etc.) |
|---|---|---|---|---|
| Cancer | | | | |
| Diabetes | | | | |
| Hypoglycemia | | | | |
| High Blood Pressure | | | | |
| Heart Disease | | | | |
| Emphysema | | | | |
| Chest Pain | | | | |
| Shortness of Breath | | | | |
| Stroke | | | | |
| Kidney Stones | | | | |
| Kidney Disease | | | | |
| Allergies | | | | |
| Asthma | | | | |
| Tuberculosis | | | | |
| Rheumatic/Scarlett Fever | | | | |
| Hepatitis | | | | |
| Liver Disease | | | | |
| Fibromyalgia | | | | |
| Polio | | | | |
| Arthritis | | | | |
| Epilepsy | | | | |
| Migraine Headaches | | | | |
| Thyroid Problems | | | | |
| Bleeding Disorder | | | | |
| Anemia | | | | |
| Depression | | | | |
| **Other:** | | | | |
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Have you had any illness or infections in the last 4 weeks? If Yes please explain:

____________________________________________

____________________________________________

____________________________________________

Do you currently or in the past month had any of the following?: Circle any that apply.

Fever, Night Sweats, Unexplained sweating, Nausea, Vomiting, Diarrhea, Fatigue, Dizziness, Fainting, Weight Loss, or Paleness.

**Symptoms: Please circle any of the following that you have had in the past YEAR.**

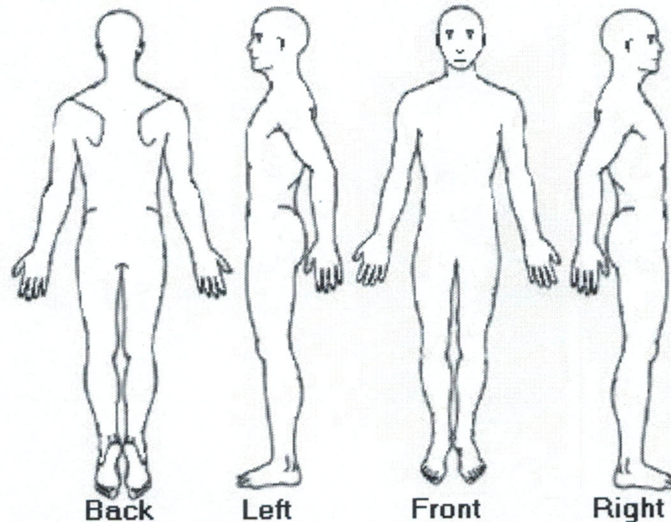
| SKIN: | OTHER: | NOSE: | URINARY TRACT: | MEN ONLY: | WOMEN ONLY: |
|---|---|---|---|---|---|
| Hives | Weight Loss | Sinus Problems | Nighttime Urination | Prostate Problems | Irregular Periods |
| Rashes | Fatigue | Nose Bleeds | History of Infections | Penis Discharge | Heavy Bleeding |
| Eczema | Night Sweats | Allergies | Painful Urination | Difficulty Urinating | Cramping |
| **EARS:** | **EYES:** | **THROAT/NECK:** | Urine Leakage | Scrotum or Testicular Pain | Menopausal Symptoms |
| Hearing Loss | Dry Eyes | Throat Irritation | Blood in Urine | Sexual Concerns | Sexual Concerns |
| Ringing | Change in Vision | Hoarseness | History of Kidney Stones | | Breast Disease |
| Infections | Glaucoma | Neck Swelling | | | Complicated Pregnancies |
| | | | | | Fibroids |
| | | | | | Endometriosis |
| **BLOOD/METABOLISM** | **HEART:** | **LUNGS:** | **DIGESTIVE:** | **MUSCLES/BONES:** | **NERVOUS SYSTEM:** |
| Unusual Hair growth | Chest Pain or Tightness | Cough | Nausea, vomiting | Painful or swollen joints | Numbness/ tingling |
| Heat or Cold intolerance | Palpitations | Wheezing | Heartburn, indigestion | stiffness | Weakness of arms or legs |
| Easy bruising | Heart Murmurs | History of Bronchitis | Difficulty swallowing | tendonitis | tremors |
| Bleeding problems | Shortness of Breath | History of Pneumonia | Abdominal pain | bursitis | headaches |
| Blood Transfusion | Swelling of legs or ankles | | Constipation or diarrhea | Back pain | Dizziness or fainting |
| Varicose Veins | Pain in legs with walking | | Bloody or black stools | Knee pain | stroke |
| | | | ulcers | gout | seizures |
| **PSYCHOLOGICAL:** | | | colitis | fractures | Frequent falls |
| Anxiety/Depression | | | gallstones | | Severe head trauma |
| Irritability | | | Liver disease | | |
| Sadness | | | Eating disorder | | |
| Anger | | | | | |
| Sleep Difficulty | | | | | |

## Condition Details

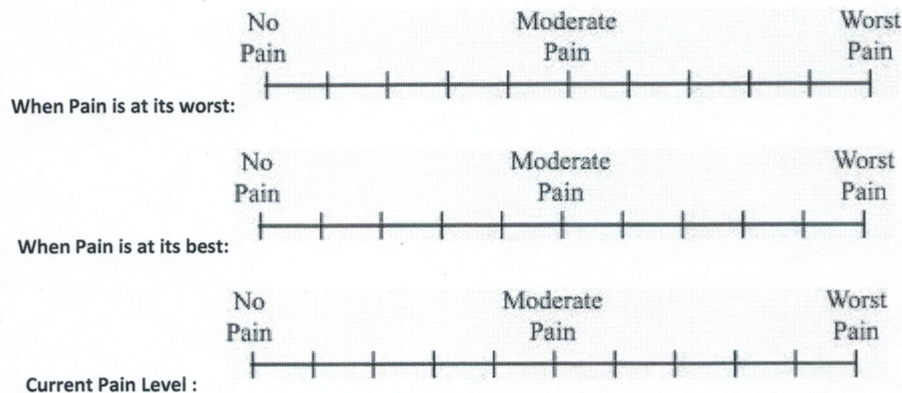
Primary Concern/ Chief Complaint: ________________________________________________

When did the symptoms appear? :______________________________Is this condition getting Worse? Yes____No____Same_____

**Mark on the diagram below the areas currently affected by your condition-**




**Please indicate your pain level on the scale below**




How often do you have the pain? ____________________ Does the pain interfere with- Work___ Sleep____Recreation____Daily Routine____

What treatments have you already received for your condition? Surgery____ Physical Therapy_____ Chiropractic_____ Other__________________

What activities ***decrease*** your pain? ________________________________________________

Which activities ***increase*** your pain? ________________________________________________

Date of Last: Physical Exam: ___/____/_____ Blood Work: ___/____/_____ X-ray:___/____/_____ Spinal Exam: ___/____/_____

MRI/CT/Bones Scan: ___/____/_____ Urine Test: ___/____/_____ Other: ______________________________

## Health History

Please check all that apply (if applicable please describe amount per day):

___ Smoking _________________ ___ Alcohol _________________ ___ Caffeine Drinks _________________

___ Recreational Drugs ______________________ ____High Stress Situations/Activity: __________________________________

**Falls:** (please check all that apply)

___ I have no falls ____ I have just started to lose my balance ____I fall occasionally

____I fall frequently (more than twice in the last 6 months) _____Certain factors make me cautious (curbs, ice, stairs and getting out of the tub)

Please check if you have a history of any of the following:

____ Broken Bones_____________________________________________________________________________

____Dislocations _____________________________________________________________________________

____ Surgeries _______________________________________________________________________________

## Medications

| Prescription: | Dosage: | Frequency: | Route: (oral, injectable, other) |
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| Over the Counter & Supplements: | Dosage: | Frequency: | Route: (oral, injectable, other) |
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Pharmacy Name: ______________________________ List any allergies to medications:__________________________________________

Patient Signature: ___________________________________ Physical Therapist Signature: _____________________________________

**For Office Use Only:**

| Height : | Weight: | B/P: | Temp: | O2 Sat: | Pulse: |
|---|---|---|---|---|---|