# Medical History/ Evaluation

Church Hill PHYSICAL THERAPY

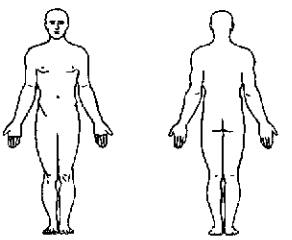
Name:_____ DOB:_____ Date:_____
Insurance:_____
General Benefits:_____
Patient Responsibility: Copay:_____/visit Deductible:_____ %Responsible_____ Patient Responsibility_____

Referring Physician:_____ Family Physician:_____
Date of Injury/Onset:_____ Date of first DR visit for this episode:_____
Current Work Status:_____ Last date worked due to this episode:_____
Level of Recreation: HIGH___ MEDIUM___ LOW_____ Home/Travel concerns:_____
Is an Attorney involved in this case? YES___ NO___
Have you had any other Diagnostic or Rehabilitative services for this injury/episode? YES___ NO___
If so, what type? (ie, X-Ray, MRI, EMG, Other):_____ Date:_____
Have you had surgery for this injury? YES___ NO___ Number of surgeries: 1 2 3 4 _____
Type of surgery:_____ Date(s) of surgery(ies):_____
Are you currently taking any prescription or non-prescription medications? YES___ NO___
Anti-Inflammatory_____ List Other Medications:_____
Muscle Relaxers_____
Pain Medication_____
How has pain changed since onset?_____

Do you have or have you ever had any of the following?

| | YES | NO |
|---|---|---|
| Asthma, Bronchitis or Emphysema | | |
| Shortness of Breath/Chest Pain | | |
| Coronary Heart Disease or Angina | | |
| Do you have a Pacemaker | | |
| High Blood Pressure | | |
| Heart Attack/Surgery | | |
| Stroke/TIA | | |
| Blood Clot/Emboli | | |
| Epilepsy/Seizures | | |
| Thyroid Trouble/Goiter | | |
| Anemia | | |
| Infectious Disease | | |
| Diabetes | | |
| Cancer or Chemotherapy/Radiation | | |
| Arthritis/Swollen Joints | | |
| Osteoporosis | | |
| Gout | | |
| Sleeping Problems/Difficulties | | |
| Emotional/Psychological problems | | |
| Bowel or Bladder Problems | | |
| Do You Smoke?_____ How much?_____ | | |
| Severe or Frequent Headaches | | |
| Vision or Hearing Difficulties | | |
| Numbness or Tingling | | |
| Dizziness or Faintness | | |

Indicate on Diagram where pain is:



| | YES | NO |
|---|---|---|
| Weakness | | |
| If so, where_____ | | |
| Weight Loss/Energy Loss | | |
| If so, where_____ | | |
| Hernia | | |
| Varicose Veins | | |
| Allergies | | |
| Any Pins/Metal Implants | | |
| Joint Replacement | | |
| Neck Injury/Surgery | | |
| Shoulder Injury/Surgery | | |
| Elbow Injury/Surgery | | |
| Back Injury/Surgery | | |
| Knee Injury/Surgery | | |
| Leg/Ankle/Foot Injury/Surgery | | |
| Are you pregnant? | | |

Alcohol Consumption?___ How much?_____

List any other information that would assist in your care:_____

Emergency Contact:_____

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Church Hill Physical Therapy, Inc. regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for the collection costs that are incurred. Also, by signing below, I acknowledge that I have read the "Notice of Privacy Practices". I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient/Parent/Guardian Signature_____ Date_____