Applied Physical Medicine

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Date_____

Patient Name_____Date of Birth_____Age_____

Address_____

City_____State_____Zip_____

Home Phone_____**Cell Phone**_____**Email**_____

Social Security Number_____Marital Status_____

Spouse's Name_____Date of Birth_____Age_____

Patient's Employer_____Occupation_____

Address_____Phone_____

Spouse's Employer_____Occupation_____

Address_____Phone_____

Dr.'s Name_____Dr. Phone_____

What is the date of your next Doctor's appointment?_____

Insurance Co._____ID#_____Group#_____

Secondary Ins. Co._____ID#_____Group#_____

Why are you here? Injury (yes / no) Wellness (yes / no) Illness (yes / no) Surgery (yes / no)

Date of surgery/injury_____

What body parts or condition are we evaluating you for today?_____

Was this injury the result of a motor vehicle accident? (yes / no)

Was this injury received on the job (work. comp) ? (yes / no)

Nearest relative not living with you_____Phone_____

Address_____

How did you hear about us?_____

I authorize Dr. Noah Abrahams, PT, DPT and his associates to release any and all medical information concerning the patient_____ to the following persons (Doctor, Spouse, etc.):

_____
_____
_____
_____

In consideration of the services rendered by the therapist, I agree to be personally liable for all charges.

I authorize my insurance company to pay medical benefits directly to Applied Physical Medicine, PLLC + Tygiel Physical Therapy, PC for all physical therapy services rendered to me by them.

In the event all charges by the therapist are not paid within a reasonable time and the therapist employs an attorney to assist in the collection of these charges, I agree to pay, in addition to the amount them owning, a reasonable amount of attorney's fees and/or court costs.

Please indicate the method of payment for your treatments:_____

Cash (y/n) check (y/n) visa/mastercard/amex (y/n)

***A $25.00 late fee will be charged for cancellation/no shows with less than 24 hours notice and/or same day cancellations. This will be collected at your next scheduled appointment.**

As a courtesy to you our patient, we will bill your insurance company directly for you, with the understanding that the contract is between you and your insurance company. We cannot be responsible for coverage determination, co-pays, deductibles, precertification, or other charges. Any amount not paid by your insurance company is solely your responsibility.

By signing, I consent to the terms stated above, and consent to outpatient physical therapy at APM.

Patient's Name (print)_____

Patient's Signature_____

The Reason for Today's Visit:

1. What date did your symptoms begin?_____

2. Please briefly describe your symptoms:

_____

_____

What makes it feel better?_____

What makes it feel worse?_____

3. How did your symptoms start?

_____

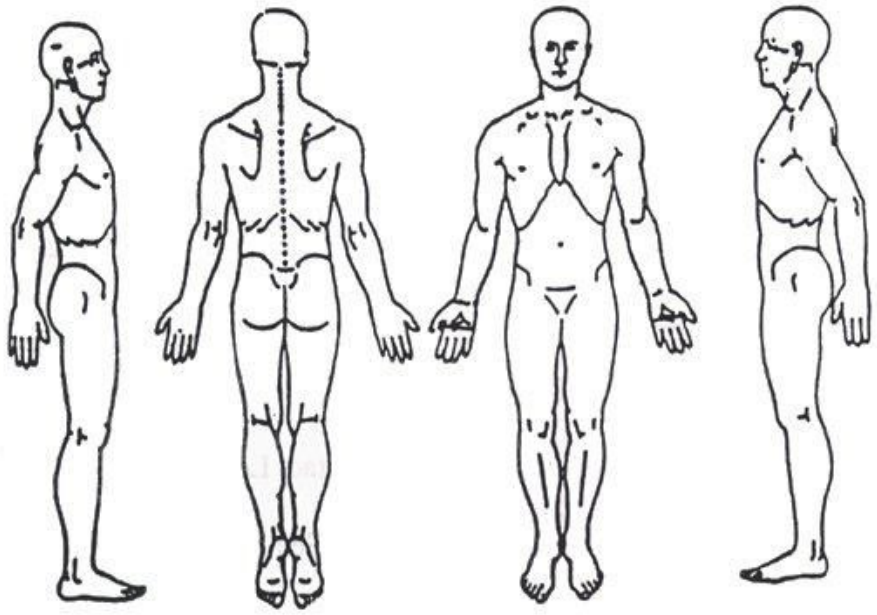
_____

_____

4. Average pain intensity (please check mark your corresponding pain level)

Area of Body	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 (worst pain)**

Please circle the area(s) where you have pain or other symptoms



5. How often do you experience you symptoms?

Constantly (76%-100% of the time)	Frequently (51%-75% of the time)	Occasionally (26%-50% of the time)	Intermittently (0%-25% of the time)

6. In general, would you say your overall health right now is...

Excellent	Very Good	Good	Fair	Poor

7. **What is your current Height?** _____ **What is your current Weight?**_____

8. Have you had any falls in the past year? (Yes / No) **How many?**_____

Blood Pressure Check in Seated position (/) *performed by clinic staff

Patient Signature: _____

Date: _____