THRIVE rehabilitation
Physical Therapy

This information is considered confidential. We need this information because we care enough to want to know and your answers will help us determine if therapy can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, write as neat and accurate as possible while filling this form.

Date:___/___/_____ Legal Name:_____
(First) (Middle) (Last)

Nickname:_____ Sex: _____ Date of Birth: ___/___/_____ SS#: _____-_____-_____

Address: _____
(Street) (City) (State) (Zip)

Mobile#: (_____)_____-_____ Home#: (_____)_____-_____ Work#: (_____)_____-_____

Consent to Email Communication: I agree to receive email communication regarding appointment updates, billing, health information, and marketing communication from Thrive Rehabilitation at the following email address.

Email:_____

Marital Status: ☐ Single, ☐ Married, ☐ Divorced, ☐ Widowed, ☐ Domestic Partner

Employment Status: ☐ Full-time, ☐ Part Time, ☐ Unemployed, ☐ Retired, ☐ Disabled

Employer Name:_____ Phone: (_____)_____-_____

Consent to Verbal Communication: I give permission to the following person(s) to receive detailed verbal information regarding my appointments, medical care, billing and payment information. I understand this **DOES NOT** authorize the disclosure of my written health information.

Name:_____Relationship:_____Phone: (_____)_____-_____

Name:_____Relationship:_____Phone: (_____)_____-_____

I understand Thrive Rehabilitation may call my home phone number or listed alternative number and leave a voicemail or in person in reference to appointment reminders, insurance or billing items. I also authorize the release of appointment information left in a voice-mail, answering machine, or text message and understand that there is some level of privacy risk associated with these forms of communication.

Emergency Contact: _____ _____ Phone: (_____)_____-_____
(Person to contact in emergency) (Relationship)

Doctors Information:

Referring Physician and Clinic**:** _____ Phone: (_____)_____-_____

Date Last Seen by Doctor: _____/_____/_____ Next appointment with Doctor: ____/_____/_____

If PCP is also referrer please check☐: Primary Care Physician: _____ Phone: (_____)_____-_____

Insurance

- Have you verified your therapy benefits/coverage with your insurance? ☐ Yes, ☐ No
- Have you had Physical/ Occupational/ Chiropractic this calendar year? ☐ Yes, ☐ No How Many Visits:_____

Primary Health Insurance Co. Name:_____ Is this policy ☐Medicare, ☐Medicaid, ☐HMO

Primary ID#:_____ Group :_____ Is this policy: ☐Self, ☐Spouse, ☐Parent

Name:_____ Their DOB:_____/____/_____Check if insured address is same ☐.

Insured Address:_____
(Street) (City) (State) (Zip)

Secondary Health Insurance Co. Name:_____ Is this policy ☐Medicare, ☐Medicaid, ☐HMO

Primary ID#:_____ Group :_____ Is this policy: ☐Self, ☐Spouse, ☐Parent

Name:_____ Their DOB:_____/____/_____Check if insured address is same ☐.

Insured Address:_____
(Street) (City) (State) (Zip)

How did you hear about us: ☐ Internet, ☐ Website, ☐ School, ☐Thrive Signage, ☐ Walk-in, ☐Local ☐ Referring Doctor, ☐ Staff Member, ☐ Sports Team, ☐Insurance website, ☐ Other

Patient/or Guardian Signature:_____ Date:___/___/____

Auto Accident / Personal Injury: Are you in a Law Suit? ☐ YES, ☐ NO

Is this an Auto Accident? ☐ YES, ☐ NO **Is this a Personal Injury?** ☐ YES, ☐ NO Date of Accident: _____

In what City and State did this Occur?_____ Auto Insurance Name:_____

Attorney Name and Firm:_____Attorney Phone: (_____)_____-_____

Claim Number:_____Adjuster Name:_____ Phone: (_____)_____-_____

Workers Compensation: Are you in a Law Suit? ☐ YES, ☐ NO Date of Injury: _____

In what City and State did this Occur?_____ Job title: _____

Attorney Name and Firm:_____Attorney Phone: (_____)_____-_____

Claim Number:_____Adjuster Name:_____ Phone: (_____)_____-_____

Medical History: Age:_____ Height:_____ Weight:_____

What is the Major reason(s) for this visit:_____

Date of symptoms, injury or when you first noticed symptoms/injury:_____/_____/_____

Where/How did injury first occur: ☐ Auto Accident, ☐ Work Accident, ☐ At home, ☐ Recreation, ☐ Other

Has any one examined you for this condition before? First treatment:____/____/_____

If so who did you see?_____

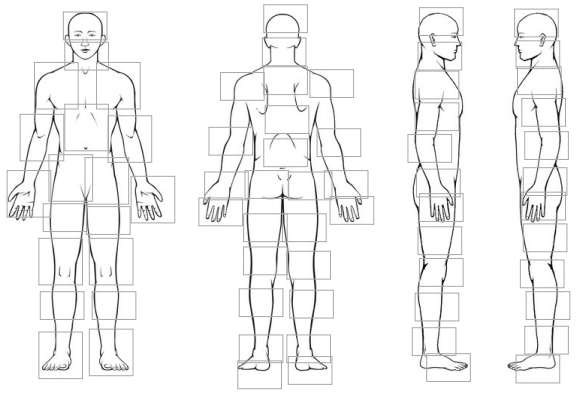
Did the doctor take: ☐ X-rays, ☐ CT Scan, ☐ MRI, ☐ Other. Do you have copies: ☐ Yes, ☐ No

How long have you had this current problem? #_____Weeks, #_____Months, #_____Years

Did you have to go to the hospital: ☐ Yes, ☐ No. Which Hospital: _____

Did the hospital take: ☐ X-rays, ☐ CT Scan, ☐ MRI, ☐ Other. Do you have copies: ☐ Yes, ☐ No

Names of all other treating doctors or treatment types:_____



Please mark location of Injury(s).

Since symptoms started they are:
☐ Staying the same, ☐ Getting worse, ☐ Improving

Symptoms currently:
☐ Come and go, ☐ Constant ☐ Change with activity

Please rate the following:

	No Pain										Excruciating
Pain currently:	0	1	2	3	4	5	6	7	8	9	10
Pain at its best:	0	1	2	3	4	5	6	7	8	9	10
Pain at its worst:	0	1	2	3	4	5	6	7	8	9	10

Please explain how injury occurred:_____

_____

What activities make your symptoms better (treatment, positions, heat/ice, etc.)?_____

_____

What makes your symptoms worse and what activities can you no longer preform because of the injury?

_____

	Inactivity										Intense Exercise
Prior physical activity:	0	1	2	3	4	5	6	7	8	9	10

Please list your normal/pre-injury recreational activities or hobbies:_____

_____

Please list your goals/expectation of therapy:

1._____ **3.**_____

2._____ **4.**_____

Patient/or Guardian Signature:_____ Date:___/___/____

Medications

List Prescription, Non-Prescription Drugs, Vitamins and Supplements used in the past 2 months:

Name	Dosage/Strength	Times per Day

Identify any other past or present injury(s) and or surgery that the doctor should know about: Please list all surgical procedures below, (I.e. Spine, Cardiovascular, Bone, Breast, Gastrointestinal or any other surgeries). Try to include the surgery year performed:

Year	Doctor/ Facility	Injury / Surgery	Injury Treatment Type

Personal Medical History :

[ ] No Known Medical History
[ ] Current Infection
[ ] Diabetes Type 1
[ ] Diabetes Type 2
[ ] Obesity
[ ] High Blood Pressure
[ ] Heart Attack
[ ] Stroke
[ ] Asthma
[ ] COPD
[ ] Pacemaker
[ ] Cardiovascular Disease
[ ] Cerebral Vascular Accident or TIA
[ ] Active Cancer
[ ] History Of Cancer
[ ] Fracture/ Suspected Fracture
[ ] Immunosuppression
[ ] Lupus
[ ] Osteoarthritis
[ ] Rheumatoid Arthritis
[ ] Parkinson's Disease
[ ] Muscular Dystrophy
[ ] Fibromyalgia
[ ] Alzheimer's/ Dementia
[ ] Concussion
[ ] Traumatic Brain Injury
[ ] List any other conditions below.

_____

Social History

	How often?			
Smoking: [ ] cigars [ ] pipe [ ] cigarettes	☐ Daily	☐ Social	☐ Occasionally	☐ Never
Alcoholic beverages:	☐ Daily	☐ Social	☐ Occasionally	☐ Never
Recreational drug use:	☐ Daily	☐ Social	☐ Occasionally	☐ Never

Family Medical History:

Does anyone in your immediate family (mother, father, siblings) have a history of Diabetes, High Blood Pressure, Cardiac Problems, Cancer, or any other hereditary conditions?

_____

_____

_____

Patient/or Guardian Signature:_____ Date:___/___/____