HAUSMANN
PHYSICAL THERAPY

PATIENT CONTACT INFORMATION **TODAYS DATE:** _________

Title: □ Mr. □ Mrs. □ Ms. □ Dr. **Date of Birth**: _______________

Gender: □ Male □ Female **Social Security Number:** _____-_____-_____

Last Name_____ **M.I.** _____ **First Name**_____

Address_____

City_____ **State**_____ **Zip Code**_____

Home Phone: (_____)_____ **Work Phone**: (_____)_____

Cell Phone: (_____)_____ **Text messages?** □ YES □ NO

E-mail address: _____

How would you like to receive appointment reminders? □ Text □ E-mail □ Voice mail

Marital Status: □ SINGLE □ MARRIED □ DIVORCED □ WIDOWED □ OTHER

Student: □ YES □ NO

EMERGENCY CONTACT: _____ Phone: _____
Relationship to patient: _____

EMPLOYMENT STATUS: □ EMPLOYED □ UNEMPLOYED □ RETIRED □ HOMEMAKER
Employer Name: _____ Employer City: _____
Supervisor: _____ Employer Phone: _____
Is this visit the result of a work related accident?: □ YES □ NO Date of Accident: ____________
Worker Compensation Information:_____

RESPONSIBLE PARTY: (Complete only if different from patient**)**
□ SELF □ SPOUSE □ CHILD □ PARENT □ OTHER:_____
Responsible Party Date of Birth: ____________ Relationship to patient_____
Last Name_____ M.I. _____ First Name_____
Address_____ City_____ State_____
Zip Code_____ Responsible Party Primary Phone number (_____)_____

INSURANCE INFORMATION: (Please present current insurance card to receptionist)
Primary Insurance Name _____ Who is insured? □ Self □ Other
If "Other", Name_____ SS#_____DOB_____
Relationship to patient_____
Secondary Insurance Name _____ Who is insured? □ Self □ Other
If "Other", Name_____ SS#_____DOB_____
Relationship to patient_____

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TODAYS DATE: _______________ **Case #_____ (Office Use Only)**

Last Name_____ M.I. _____ First Name_____

Date of Birth: _______________

What is the reason for your visit today?_____

What is the location of your pain?_____

When did this problem begin?_____

Is this a work related injury? □Yes □No Date of injury: _____

Is this worker compensation case? □Yes □No Workers Comp Company: _____

Is this the result of an auto accident? □Yes □No Date of injury: _____

My symptoms are: □ **Constant** (all day pain regardless of position or activity)
□ **Intermittent** (change with activity or position)

Things that worsen my symptoms: _____

Things that reduce my symptoms: _____

Doctor who referred you: _____

Family Doctor: _____

Please list any surgeries or injuries related to your visit today:

_____

_____

_____

Please list any additional you would like to discuss during your visit today:

_____

_____

_____

Health History Questionnaire (Confidential)

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First Name:_____

Last Name: _____

Date of Birth: _____/_____/_____

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

Yes No

- □ □ AIDS/HIV Positive
- □ □ Alzheimers
- □ □ Amputation If yes, explain: _____
- □ □ Artificial Joint If yes, explain: _____
- □ □ Arthritis
- □ □ Asthma
- □ □ Back/Neck Pain
- □ □ Blood Clots
- □ □ Cancer If yes, explain: _____
- □ □ Carpal Tunnel Syndrome
- □ □ Chronic Headaches
- □ □ Diabetes
- □ □ Dizziness
- □ □ Double Vision
- □ □ Emphysema
- □ □ Epilepsy or Seizures
- □ □ Head Injury
- □ □ Heart Condition If yes, explain:_____
- □ □ Hepatitis A, B, or C If yes, explain:_____
- □ □ High Blood Pressure
- □ □ Ligament or Tendon Injury If yes, explain: _____
- □ □ Loss of Use of Limbs: If yes, explain: _____
- □ □ Latex Allergy
- □ □ Numbness of Extremities If yes, explain:_____
- □ □ Mental Disorder If yes, explain: _____
- □ □ Multiple Sclerosis
- □ □ Muscle Injury If yes, explain:_____
- □ □ Muscular Dystrophy
- □ □ Parkinson's Disease
- □ □ Rotator Cuff Injury If yes, explain: _____
- □ □ Ruptured Disc If yes, explain: _____
- □ □ Shingles
- □ □ Spinal Fusion If yes, explain: _____
- □ □ Stroke If yes, explain: _____

Are you using, or have you ever used any of the following:

Yes No

□ □ **Prescription Drugs** If yes, explain:

_____
_____
_____
_____

□ □ **Over-the-Counter Drugs** If yes, explain:

_____
_____
_____

□ □ **Tobacco** If yes, explain:

_____
_____
_____

□ □ **Natural remedies** If yes, explain:

_____
_____
_____

Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:

_____
_____
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform Hausmann Physical Therapy of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: _____**DATE**:_____

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CONSENT TO TREATMENT

I understand that I have been referred for physical therapy treatment to Hausmann Physical Therapy PC. Hausmann Physical Therapy PC will provide an individualized treatment plan. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to this treatment plan that has been prescribed by my physician and/or recommended by my physical therapist. By signing this agreement, I consent to have Hausmann Physical Therapy PC provide treatment and care as prescribed by my physician and/or recommended by my therapist.

Patient Signature_____ **Date**_____

CREDIT AND BILLING POLICY

Unless previous arrangements have been made, co-pays are expected at the time of service. As a courtesy to our patients, we will contact your insurance company to verify eligibility and benefits as they pertain to your individual insurance plan. We also encourage you to contact your insurance company to verify your benefits. The cost of services is ultimately the responsibility of the patient.

CANCELLATION POLICY

Please notify our clinic if you are unable to keep your scheduled appointment.
HAUSMANN PHYSICAL THERAPY WILL IMPOSE A $25 FEE FOR ALL NO CALL/NO SHOW APPOINTMENTS

Patient Signature_____ **Date**_____

ASSIGNMENT OF BENEFITS

I authorize any benefits payable under my insurance plan for services proved to be paid directly to Hausmann Physical Therapy PC. I also authorize the release of any information required in the course of my evaluation and treatment to the appropriate agencies. I understand that I am responsible for any amount not covered by my insurance. **Medicare patients only:** I request that payment of authorized Medicare benefits be made to Hausmann Physical Therapy PC for services provided. I also authorize release of medical information.

Patient Signature_____ **Date**_____

HAUSMANN
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Hausmann Physical Therapy, PC

Acknowledgement of Receipt of Notice of Privacy Practices

Hausmann Physical Therapy, PC reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the Notice of Privacy Practices for Hausmann Physical Therapy, PC

_____
Name of Patient (Print or Type)

_____ **Date**: _____
Signature of Patient

_____ **Date:** _____
Signature of Patient Representative (Required if patient is a minor or adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient