# PATIENT DEMOGRAPHICS

Patient's Name ____________________________________________ Date of Birth __________
(last) (first) (middle)

Mailing Address ___________________________________________________________________
(number and street) (city) (state) (zip)

Home # (___) _________ Cellular # (___) _________ Work # (___) __________

Social Security # _______________________ Employer _______________________________

Email address ______________________________ Marital Status (circle) Married Single Widowed

In Case of Emergency Contact __________________________ Phone # (___) _____________

Referring Physician _______________________________ Date of Injury ___________________

Primary Care Physician _____________________________________________________________

Would you like us to provide appointment reminders? Y/N
Select how you would like to receive a reminder:
☐Email ____________________________ ☐Phone Call ___________________ ☐Text ___________________

**► INSURANCE – Please provide Insurance Card for Copying◄**

Primary Insurance Name and Address _________________________________________________________

Subscriber's Name ________________________________ Group # ________________ ID # __________________

Secondary Insurance Name and Address _______________________________________________________

Subscriber's Name ________________________________ Group # ________________ ID # __________________

► Workers Compensation Carrier ◄ _____________________________ Claim # ____________________________

**► IF PATIENT IS UNDER THE AGE OF 18 ◄**

Mother's Name _____________________________________________ Employer _____________________________

Work # (___) _________________________________ Social Security # ___________________________________

Father's Name ______________________________________________ Employer ____________________________

Work # (___) _________________________________ Social Security # ___________________________________

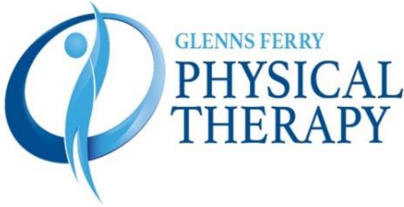
For patients under 18 years of age, the parent, relative, or person *escorting* the patient is responsible for any payments due at the time of the service.

- I understand that I am responsible for all charges incurred regardless of insurance or third party liability.
- I authorize contact by the use of my mobile/cell phone number for discussing treatment, confirming appointments and resolution of the balance of my account.
- I authorize Glenns Ferry Physical Therapy to release any medical information necessary to process my claim to my insurance company or to any other concerned third party.
- I understand that I will bear the cost for all associated collections and/or attorney/legal fees if my account is placed with a 3rd party agency and/or attorney for collections or legal action.
- I authorize my insurance company or any other concerned third party to make payment directly to Glenns Ferry Physical Therapy.

_______________________________________________ __________________
**Signature** **Date**

**Glenns Ferry Physical Therapy Financial Policy**

PO Box 293. • Glenns Ferry, ID 83623
(208) 696-9711 • Fax (4208) 656-5646• www.glennsferrypt.com




# Patient Health History

Patient's Name ________________________________________ Date of Birth ____________

Type of Injury/Condition _______________________________________________________

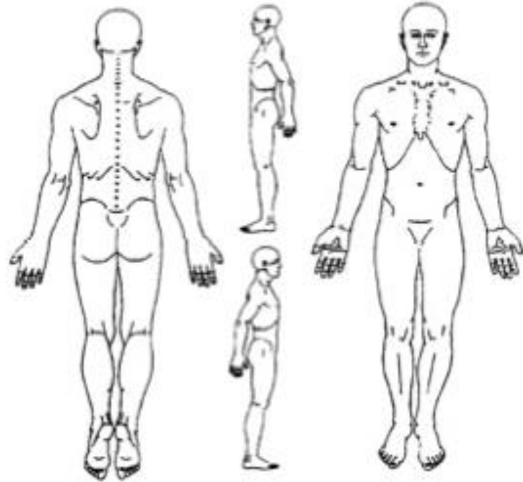
Date of Injury __________________Surgery (circle) Yes / No Date of Surgery__________

If Yes, Type of Surgery_________________________________________________________

Next Doctors Appointment? _____________________

Describe previous treatment for this condition_______

___________________________________________



Have you received Physical therapy this year? Yes / No

Have you received Speech therapy this year? Yes / No

Have you received Home Health this year? Yes / No

Are you currently Pregnant? Yes / No

Have you had any recent imaging performed? Yes / No

If yes please describe type and location ____________

____________________________________________

Have you recently noted:

- ☐ Weight Loss/Gain
- ☐ Weakness
- ☐ Pain w/ Coughing/Sneezing
- ☐ Pain at Night
- ☐ Nausea/Vomiting
- ☐ Fever/Chills/Sweats
- ☐ Headaches
- ☐ Cramps in Legs when walking
- ☐ Fatigue
- ☐ Numbness/Tingling
- ☐ Change in Vision
- ☐ Insomnia

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

- ☐ Surgeries
- ☐ Sprains/Strains
- ☐ Heart Problems
- ☐ Circulation Problems / Clots
- ☐ Easy Bruising / Bleeding
- ☐ Allergies/Skin Sensitivity
- ☐ Loss of consciousness
- ☐ Diabetes
- ☐ Cancer
- ☐ Asthma/Breathing Problems
- ☐ Leg / Ankle Swelling
- ☐ Fainting
- ☐ Fractures
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Vehicle Accident
- ☐ Lung Disease
- ☐ UTI/Infections

Are you currently taking any medication? Yes / No Name or Type of Medication ________________
_________________________________________________________________________________

Please describe your Type of Pain (if Applicable) -Sharp -Burning -Aching -Tingling -Numbness

-Other _________________________ Rate you Pain (Average) 1-10 (1=min, 10=severe)_________

What do you expect to accomplish or be able to do better with physical therapy? ________________
_________________________________________________________________________________
_________________________________________________________________________________