PATIENT INFORMATION

Name:____SSN#:_______-________-________
First MI Last (REQUIRED FOR WORK COMP)

☐ Male ☐ Female Date of Birth___/____/____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address:____
Street Address City State Zip

Email Address:________________________________ Cell Phone: (____) ______-____________

Would you like to receive appointment reminders by email?

☐ Yes, notify me by email ☐ No, Do not email me

Would you like to receive appointment reminders by text?

☐ Yes, text me ☐ No, Do not text me

Emergency Contact:__________________________ Relationship:____________________________

Phone#_____________________________________

Claim #:____________________________________

Date of Injury_______/______/_______

Employer:___________________________________
At time of Injury

Employer Phone (_____) ________-________

Employer Address:____
(City Required) Street Address City State Zip

Referring Physician:______________________________________ City: __________________________________

CONSENT FOR TREATMENT

I the Undersigned do hereby agree and give my consent for **Beachside Physical Therapy** to furnish physical therapy care and treatment considered necessary and proper in evaluating and/or treating my physical condition. It is your responsibility to notify our office of any patient information changes (i.e., address, phone number, name, insurance information, etc.)

Signature:____ Date:___________________________

NON-COMPLIANCE NOTIFICATION

Your therapist, physician, adjuster, and case manager work together to assist with your return to full function in the workplace. In order for your treatment to have maximal effect and progress, all prescribed therapy sessions must be attended. To comply with the workers' compensation laws, we are required to notify the adjuster, case manager and physician of missed appointments. If for any reason, you are unable to attend, please call in a timely manner and we will reschedule your appointment and inform your adjuster. Missed appointments may result in discontinuation of workman's compensation benefits.

Signature____**Date**__________________________________

WORKERS' COMPENSATION CARRIER/ ATTORNEY & ADJUSTER INFORMATION

Carrier:____________________Adjuster's Name ___________________ Adjuster Phone: (____) ____-____

Claims Mailing Address:____
Street Address City State Zip

Attorney Name:_____________________________________ Attorney Phone (_____) ________-_________

Mailing Address:____
Street Address City State Zip

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION OF RELEASE OF SPECIFIC INFORMATION

Beachside Physical Therapy reserves the right to modify the privacy practices outlined in this notice.

I acknowledge that I have received or have had the opportunity to receive a copy of the official Notice of Privacy Practices from Beachside Physical Therapy, Inc.

Signature:_______________________________ Date:_____________________

By signing this authorization, I understand that this does not authorize release of medical information by Beachside Physical Therapy, Inc. to any other organization or agency unless I grant further authorization. I also understand that these authorizations may be revoked at anytime.

Signature:__________________________________ Date:___________________

Initial all statements that apply:

__________I authorize you to leave messages regarding my appointments on my answering machine or voicemail as listed on my patient information.

__________I authorize you to discuss my appointments with my spouse as listed on my patient information.

__________In addition to my referring doctor, I authorize you to communicate with and send reports & evaluations to the following:

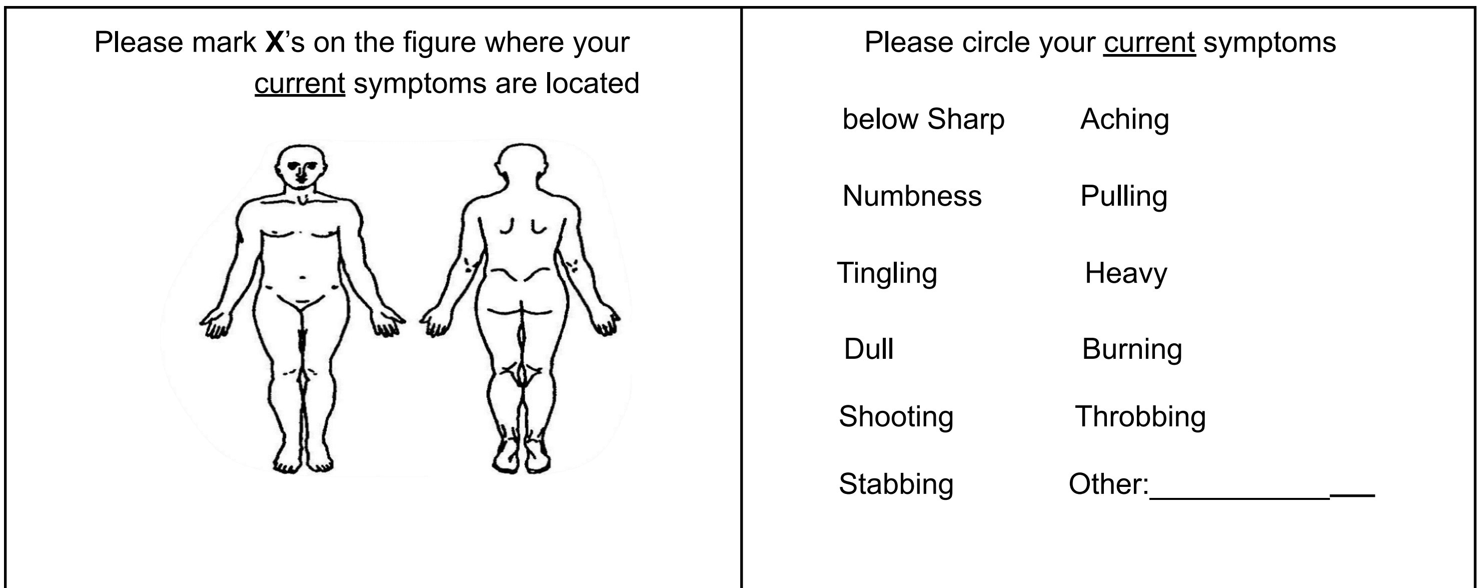
__________I agree to enroll in the electronic statement service and consent to receive my periodic account statements electronically

HEALTH HISTORY

Patient Name:_________________________________ Height___Weight____ Date of Birth__/___/

CURRENT COMPLAINTS

Did your injury result in surgery? If so, what was the date of surgery _/_____/_____
Have you ever had a similar injury/condition in the past?_______________________________________
Is your injury/condition **getting better**, **staying the same**, or **getting worse**? (Circle one)



Please mark **X**'s on the figure where your current symptoms are located	Please circle your current symptoms	
	below Sharp	Aching
	Numbness	Pulling
	Tingling	Heavy
	Dull	Burning
	Shooting	Throbbing
	Stabbing	Other:_____________

Rate your pain level over the last week at its best and at its worst on the scale below

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 **UNBEARABLE PAIN**

On the percentage scale below, circle your current level of overall function

NO RESTRICTIONS 100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0% **UNABLE TO FUNCTION**

Do you have any work restrictions ☐ Yes ☐No

If no, please list any specific limitations you have due to your current condition:____________________________

MEDICAL HISTORY

Please circle YES for applicable conditions. Or NO for all conditions.

Allergies	Yes	No	Diabetes	Yes	No	Metal Implants	Yes	No
Anemia	Yes	No	Dizzy Spells	Yes	No	MRSA	Yes	No
Anxiety	Yes	No	Emphysema/Bronchitis	Yes	No	Multiple Sclerosis	Yes	No
Arthritis	Yes	No	Fibromyalgia	Yes	No	Muscular Disease	Yes	No
Asthma	Yes	No	Fractures	Yes	No	Osteoporosis	Yes	No
Autoimmune Disorder	Yes	No	Gallbladder Problems	Yes	No	Parkinsons	Yes	No
Cancer	Yes	No	Headaches	Yes	No	Rheumatoid Arthritis	Yes	No
Cardiac Conditions	Yes	No	Hearing Impairment	Yes	No	Seizures	Yes	No
Cardiac Pacemaker	Yes	No	Hepatitis	Yes	No	Smoking	Yes	No
Chemical Dependency	Yes	No	High Cholesterol	Yes	No	Speech Problems	Yes	No
Circulation Problems	Yes	No	High/Low Blood Pressure	Yes	No	Strokes	Yes	No
Covid-19	Yes	No	HIV/AIDS	Yes	No	Thyroid Disease	Yes	No
Currently Pregnant	Yes	No	Incontinence	Yes	No	Tuberculosis	Yes	No
Depression	Yes	No	Kidney Problems	Yes	No	Vision Problems	Yes	No

Describe any other conditions:

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Medical Precautions:

FALL HISTORY

Injury as a result of a fall in the past year? ☐ Yes ☐ No Date of Fall: ____________________

Two or more falls in the last year? ☐ Yes ☐ No Dates of Falls: ____________________

Patient is at risk for fall? Yes No N/A

SURGICAL HISTORY

related to the current condition

Body Region:____________________________Surgery Type:__________________Date of Surgery:________

Body Region:____________________________Surgery Type:__________________Date of Surgery:________

Body Region:____________________________Surgery Type:__________________Date of Surgery:________

CURRENT MEDICATIONS

Drug	Dosage	Frequency	Route	Reason for Taking