PHYSICAL THERAPY SERVICES OF BROOKSVILLE, INC.

MEDICAL HISTORY FORM

Name: _____ Diagnosis: _____

Referring Physician: _____ Primary Care Physician: _____

Date that you will be returning to the physician that referred you to therapy:_____

Are you presently working? YES _____ NO _____ Dominant Side: RIGHT _____ LEFT _____

Have you had any type of therapy? YES _____ NO _____

Have you had any falls in the last year? YES _____ NO _____ If so, how many? _____

Is this injury due to work? YES _____ NO _____ Is this injury auto related? YES _____ NO _____

Have you ever been clinically diagnosed with Dementia? YES _____ NO _____

If YES please list the name of the physican that made the Dementia diagnosis _____

Have you ever been clinically diagnosed with Depression? YES _____ NO _____

Have you ever been clinically diagnosed with Bipolar Disorder? YES _____ NO _____

MEDICAL PROBLEMS

☐ Pacemaker	☐ Heart/Lung Disease	☐ Hypertension	☐ Heart Attack
☐ Diabetes - Type I or II	☐ Cancer	☐ Respiratory Illness	☐ Kidney Disease
☐ Hepatitis	☐ Epilepsy	☐ Head Injury	☐ Light-headedness
☐ Rectal Pain	☐ Sciatica	☐ Endometriosis	☐ Lupus
☐ Pelvic/Vulvar Pain	☐ Bowel Problems	☐ Fibromyalgia	☐ Strokes
☐ Hip Pain	☐ Arthritis	☐ TMJ	☐ Seizures
☐ Knee Pain	☐ Osteoporosis	☐ Leg Cramps	☐ Broken Bones
☐ Back Pain	☐ Spinal Stenosis	☐ Blood Clots	☐ Any Metal Implants
☐ Neck Pain	☐ Rheumatoid Arthritis	☐ Interstitial Cystitis	☐ Currently Pregnant
☐ Ankle/Foot Pain	☐ Pelvic Inflammatory Disease	☐ Mental Disorder	☐ Infectious Disease
☐ Shoulder/Elbow/Wrist Pain	☐ Pain/Difficulty Urinating	☐ Unusual Reaction to Hot or Cold	

SURGERIES AND DATES

☐ Hysterectomy	_____	☐ Prostate	_____
☐ Hernia Repair	_____	☐ Gall Bladder	_____
☐ Orthopedic Surgery	_____	☐ Kidney	_____
☐ Bladder Repair	_____	☐ Cardiac	_____
☐ Appendectomy	_____	☐ Other	_____
☐ C-Section	_____	☐ Disabled Yes No	Why?_____

ALLERGIES

MAJOR HOSPITALIZATIONS

Name: _____

EXPECTATIONS/GOALS FOR THERAPY

Are you aware of the Diagnosis/Prognosis? YES _____ NO _____

Do you have an Advanced Medical Directive (Living Will)? YES _____ NO _____

Would you like information about a Living Will? YES _____ NO _____

Whom may we thank for referring you? _____

I have read and filled out the history questionnaire to the best of my knowledge.

Signature _____ Date: _____

PHYSICAL THERAPY SERVICES

Of BROOKSVILLE, Inc.	Of SPRING HILL	Of SUMTER	Of SUMTER *At Langley*
20195 Cortez Blvd.	3247 Commercial Way	413 West Street	1389 Hwy. 301, Suite A
Brooksville, FL 34601	Spring Hill, FL 34606	Bushnell, FL 33513	Sumterville, FL 33585
Ph: (352) 754-4500	Ph: (352) 683-4551	Ph: (352) 569-0004	Ph: (352) 569-1088
Fax: (352) 754-9343	Fax: (352) 683-8957	Fax: (352) 569-0090	Fax: (352) 569-1090

Patient Medication List

Patient Name:______________________________________ Date: __________

Medication	Dosage	Frequency	Route
____________	______	________	Oral/Topical/Injection/Inhalation
____________	______	________	Oral/Topical/Injection/Inhalation
____________	______	________	Oral/Topical/Injection/Inhalation
____________	______	________	Oral/Topical/Injection/Inhalation
____________	______	________	Oral/Topical/Injection/Inhalation
____________	______	________	Oral/Topical/Injection/Inhalation
____________	______	________	Oral/Topical/Injection/Inhalation
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____________	______	________	Oral/Topical/Injection/Inhalation
____________	______	________	Oral/Topical/Injection/Inhalation
____________	______	________	Oral/Topical/Injection/Inhalation
____________	______	________	Oral/Topical/Injection/Inhalation
____________	______	________	Oral/Topical/Injection/Inhalation

Patient Signature____

Patient Communication Authorization

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of the PHI is made alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (please check all that apply):

( ) Home Phone Number: _____
( ) Ok to leave a message with detailed information ( ) Leave message with call back number ONLY

( ) Cellular Phone Number: _____
( ) Ok to leave a message with detailed information ( ) Leave message with call back number ONLY

( ) Work Phone Number: _____
( ) Ok to leave a message with detailed information ( ) Leave message with call back number ONLY

Verbal Authorization

Verbal Authorization received to discuss protected health information of the above patient with the following next of kin:

_____ _____
Name Relationship

_____ _____
Name Relationship

Acknowledgment

Physical Therapy Services of Brooksville, Inc. Notice of Privacy Practices was given to me upon signing and is also permanently posted in the lobby at each facility.

_____ _____
Print Name Date of Birth

_____ _____
Signature Date

Physical Therapy Services of Brooksville, Inc.
Patient Information Sheet
(Please Print)

Date: _____

Patient Name: _____ Birth Date:_____

Patient Mailing Address: _____

City:_____ State: _____ Zip:_____

Phone Number: (____)_____ Cell Number: (____)_____

S.S. Number: _____ Email Address: _____

Sex: M____ F____ Marital Status: M____ S____ D____ W____ Other_____

Are you presently working? Yes ___ No ___ Have you had any type of therapy? Yes ___ No ___

How did you hear about us?_____

Referring Physician:_____ Date you will return to referring physician:_____

Guarantor Name: _____ Birth Date: _____

Guarantor Address: _____

City:_____ State: _____ Zip:_____

Phone Number: (____)_____ S.S. Number: _____ Sex: M____ F____

IN CASE OF EMERGENCY PLEASE LIST NAME AND PHONE NUMBER OF 2 PEOPLE WE MAY CONTACT:

Name: _____ Relationship _____ Phone Number:_____

Name: _____ Relationship _____ Phone Number:_____

Accident Related? Yes___ No___ Type: Work___ Auto___ Other___ Date of Injury:_____

Accident Details:_____

_____

_____

***Employer information must be completed for Workman's Compensation:**

Employer:_____ Phone Number:_____

Address:_____

I, hereby authorize Physical Therapy Services of Brooksville, Inc. to administer services deemed advisable in treatment to physicians diagnosis. I hereby, authorize the above insurance company to pay any medical benefits to which I am entitled directly to Physical Therapy Services of Brooksville, Inc. I, hereby authorize said assignee to release all information necessary, including medical records, to secure payment. It is understood that the undersigned and patient are solely responsible for payment of patient's bill.

Patient/Guardian_____ **Date:**_____