MOMENTUM PHYSICAL THERAPY #_____

First Name Middle Initial Last Name

Home Address_____

City_____ State_____ Zip Code_____

E-mail address_____ SS#_____

Date of birth_____ Age_____ Male / Female

Please circle: **Single** **Married** **Widowed** **Divorced**

Home phone # (___) _____ Work phone # (___) _____ Cell phone # (___)_____

We are required to communicate with your doctor for both insurance and treatment coverage purposes.

Medical Doctor Name_____ Phone # (___)_____

Employer_____ Occupation_____

In case of emergency contact_____ Phone # (___)_____

Nearest relative not living with you_____ Contact phone # (___)_____

Please name the person who referred you here_____

Health Insurance Information

Insurance Company name_____

Insurance carried under: **self** **spouse** **parent** **other**

YOUR insurance policy is between **YOU** and **YOUR** insurance company. **We** are **Not** a part of this relationship.

Name of insured_____ Date of Birth_____

Insured Address_____ City_____ State____ Zip____

The employer's name that covers the insured_____

ID/Group # on insurance card_____

I authorize the use of this information for insurance billing, the release of information to the insurance company, I am responsible for my charges for service, and authorize payment to Spine & Neuromuscular Associates of S.E.I., P.S.C., and permit a copy of this authorization to be used in place of the original. My insurance policy is an agreement between me and my insurance company.

We will file your claims as a courtesy to you however; you are ultimately responsible for all bills and may be responsible for out of network charges and deductibles/ Co-payments are due at the time of service. "NO SHOWS" WILL BE BILLED if you don't give us a 24 hours notice

SIGNATURE: _____ DATE: ____/____/____

MOMENTUM PHYSICAL THERAPY #____

Confidential Case History for Physical Therapy

Name:_____ DOB:_____

-Please List Your Chief Complaints:

1. _____
2. _____
3. _____

-Do you feel your symptoms are **mild, moderate, or severe**? _____

-What worsens your symptoms? _____

-How long have your symptoms been present? _____

-What makes your symptoms better? _____

-How did you symptoms start? **Suddenly** **Gradually** **Unknown**

-Are your symptoms: **Constant** **Progressive** **Intermittent**

-Have you experienced similar symptoms in the past? Y / N

-Have you had any prior treatments or testing performed for this problem? If so include when, where, and what was performed? _____

_____

_____

-What is the date of your injury (include multiple dates if necessary)? _____

-What type of injury did you experience? **Auto Accident** **Personal Injury** **Workers Compensation**

-Have you had past injuries that we should know about? Y / N Please list the year and type of injury.

_____

-Please list all medications you are currently or recently have been on. _____

_____

-Please list all surgeries you've ever had (including breast implants). _____

_____

-Please list any past or current illnesses that you feel are significant. _____

_____

SIGNATURE: _____ DATE: ____/____/____

MOMENTUM PHYSICAL THERAPY #____

-Please list any history of family illness (diabetes, high blood pressure, etc) _____

_____

-Please circle the # of times you have fallen in the past year (a fall is an unintentional displacement of the body in which you land on a lower surface, not necessarily the ground).

0 1 2 3 4 5 6 7 8 9 10+

-Please list the number of falls in the last year that have produced an injury lasting 2 days or longer. ____

-Do you have a fear of falling? Yes / No

-Please circle your type of tobacco use: None Cigarettes Cigars Pipe Chew Dip
Quit_____

-Do you exercise (work, errands, and child care are not considered exercise)? ***Please mark the level***

None

Occasionally (1-2 times a week for at least 1 hour total)

Intermittently (3-4 x weekly for 3-4 hours total)

Regularly (4-6 times a week for 3-8 hours total)

Avidly (6-14 times a week for 10+ hours)

-Please mark the physical level of your job or regular activity that would take the place of a job.

Minimal (primary activity is sitting or lying largely supported)

Posture Intensive (seated without/or minimal support as with heavy computer use)

Intermittent (Office work with a moderate level of walking regularly but minimal lifting)

Moderate (Office work with regular lifting 5-10 lbs., walking, and long periods of standing)

High Intensity (Lifting 10-50 lbs. with regularity, and intermittent sweating from exertion not heat)

Heavy Duty (Lifting of 20-100 lbs. with regularity, regular periods of sweating and moderate-heavy fatigue by the end of the day)

-Have you tested positive for HIV/Aids or Hepatitis? Yes / No

-Have you experienced any recent traumas such as divorce, the death of a family member or friend, job loss, change in residence?

_____

-***Please circle*** your race: Asian **Caucasian African American Hispanic Other**_____

SIGNATURE: _____ DATE: ____/_____/_____

MOMENTUM PHYSICAL THERAPY #____

Circle the highest level of education completed (not attempted):

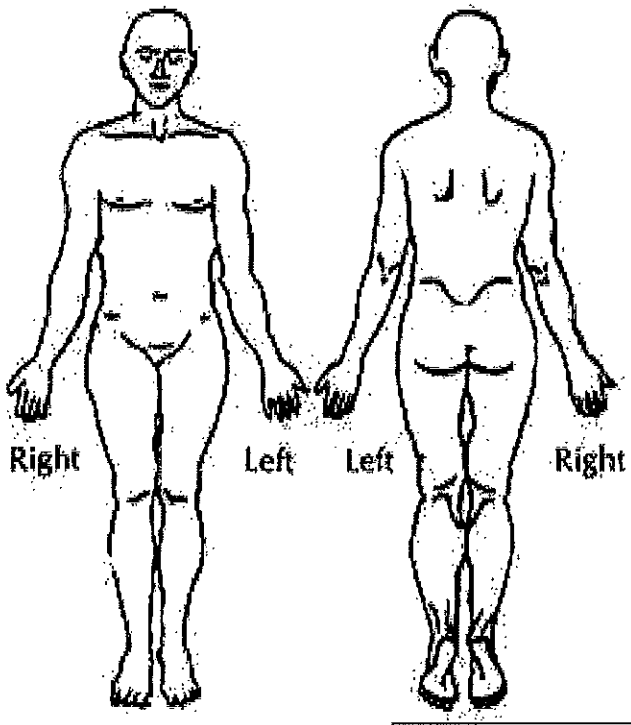
Elementary Middle High School Certificate Associates Bachelors Masters Doctorate

Do you have any electrical equipment implanted under your skin? (Example: pacemaker, electrical shunt, spinal cord stimulator) Yes / No

Do you or have you ever had Cancer? (Please list when, where, and if you are still active with any treatments.) _____

BODY PAIN CHART

Instruction: Please indicate the location, type, and intensity of your pain using the symbols below, show which area of body that symbol exists.



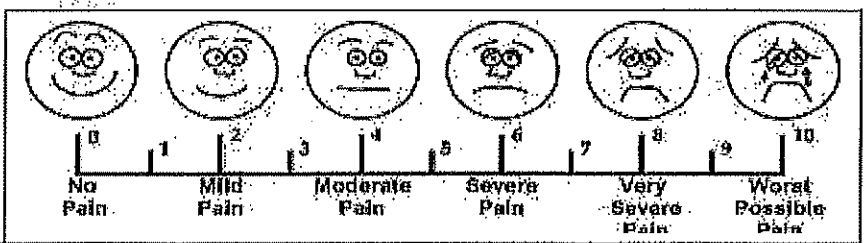
000 pins & needles

xxx burning

/// stabbing

*** aching

---- numbness



MEDICARE DMEPOS SUPPLIER STANDARDS

The products and/or services provided to you by (Spine & Neuromuscular Associates of S.E.I., P.S.C) are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulation Section 424.57©. These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at Http://ecfr/gpoaccess.gov. Upon request we will furnish you a written copy of the standards.

SIGNATURE: _____ DATE: ____/_____/_____