THE PHYSICAL THERAPY ZONE

127A North Washington Street, Alexandria, VA 22314 / Phone: (703) 837-0010 / Fax: (703) 837-0060

PATIENT INFORMATION

Last Name: _____ First: _____ MI: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

Soc. Sec. _____ DOB _____ Age: _____ Sex: _____ Marital Status: _____

Referring Physician _____ Phone: _____

WORK INFORMATION

Employer: _____ Phone: _____

Address:_____

Occupation: _____ Employment Status: _____

HEALTH INSURANCE INFORMATION

Primary Insurance: _____Phone: _____

Policy#: _____ Group #: _____ Subscriber: _____

Relationship to Subscriber: _____ Soc. Sec.: _____ Phone: _____

Secondary Insurance: _____ Phone: _____ Policy #: _____

Subscriber's Name: _____ Relationship to Subscriber: _____

Were you involved in an accident? _____Yes _____No Date of Injury: _____

Please circle one Auto / WC / Miscellaneous In what state did the accident occur? VA DC MD _____Other

Insurance Name: _____ Phone: _____ Claim #: _____

Adjustor/Case Mgr Name: _____ Phone: _____

Third Party Insurance: _____ Phone: _____ Claim #: _____

Adjustor/Case Mgr Name: _____ Phone: _____

EMERGENCY CONTACT (PERSON NOT RESIDING WITH PATIENT)

Name: _____ Relationship to Patient: _____ Phone: _____

Name of Spouse: _____ Employer: _____ Phone: _____

Signature _____ **Date:** _____

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ATTORNEY INFORMATION

Name: _____ Phone: _____ Fax: _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physical therapist and is not a substitute for payment. Some companies may pay fixed allowances for certain procedures; sometimes referred to as "Reasonable and Customary Fees". We do not accept this as payment in full (unless otherwise restricted by law or agreement we may have with your insurer). In addition, some insurance companies only pay a percentage of the fees for services rendered. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance. IN ORDER TO CONTROL BILLING COSTS, WE REQUEST THAT OFFICE VISITS FEES TO BE PAID AT THE INITATION OF EACH VISIT. In the event your account is transferred to collections, collection and/or legal fees, including attorney fees shall be your responsibility.

I hereby assign all medical benefits to include major medical benefits to which I am entitled, Medicare, private insurance and other health plans to the facility listed in the top header of this page. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment, via fax transmittal or hard copy.

Signature _____ **Date:** _____

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MEDICAL HISTORY DISCLOSURE FORM

Name: _____ Age & Date of Birth: : _____

What areas of the body (i.e. neck, left hip, right knee, etc.) or conditions (i.e. Fibromyalgia, osteoarthritis, etc.) are you currently seeking physical therapy treatment for?

If there are multiple areas of involvement, which region/problem is of greatest concern at this time?

Have you ever been treated for this same problem before? If so, when and who treated this problem (i.e. 2001 by John Doe, DC and Jane Smith MSPT)?

Please check any illnesses you've either had in the past or currently have:

____ Cardiovascular Disease	____ Asthma/Breathing Difficulty	____ Hepatitis/Liver Disease	____ Depression
____ High Blood Pressure	____ Congestive Heart Failure	____ Epilepsy/Seizures	____ Anemia
____ Diabetes (I or II)	____ Multiple Sclerosis	____ Thyroid Condition	____ Osteoperosis
____ Heart Attack or Stroke	____ Fibromyalgia	____ Neurological Condition	____ Chronic Infec
____ Arthiritis (Osteo / Rheum)	____ Migraines/Headaches	____ Eating Disorder	____ Lupus
____ Kidney/Renal Disease	____ Dizzy/Vertigo	____ Drug or Alcohol Abuse	____ HIV/AIDS

____ Cancer (Type _____; Location(s) _____; Year _____; Status _____

____ Other _____

Do you have a pacemaker, internal defibrillator, insulin pump, metal fixator, or any other implanted medical device?

Are you currently pregnant or is there a possibility that you may be pregnant?

Please list all prescription medications you are presently taking and the reason for the medication (i.e. Prozac for Depression, Percocet for pain, Accupril for High Blood Pressure):

What type of exercise and/or sports, if any, do you perform or participate in?

I CERTIFY, TO THE BEST OF MY KNOWLEDGE, THAT THE ABOVE INFORMATION IS COMPLTETE AND TRUE. IF MY MEDICAL/HEALTH STATUS CHANGES, I WILL INFORM THE PHYSICAL THERAPY ZONE IMMEDIATELY.

Signature: _____ Date: _____

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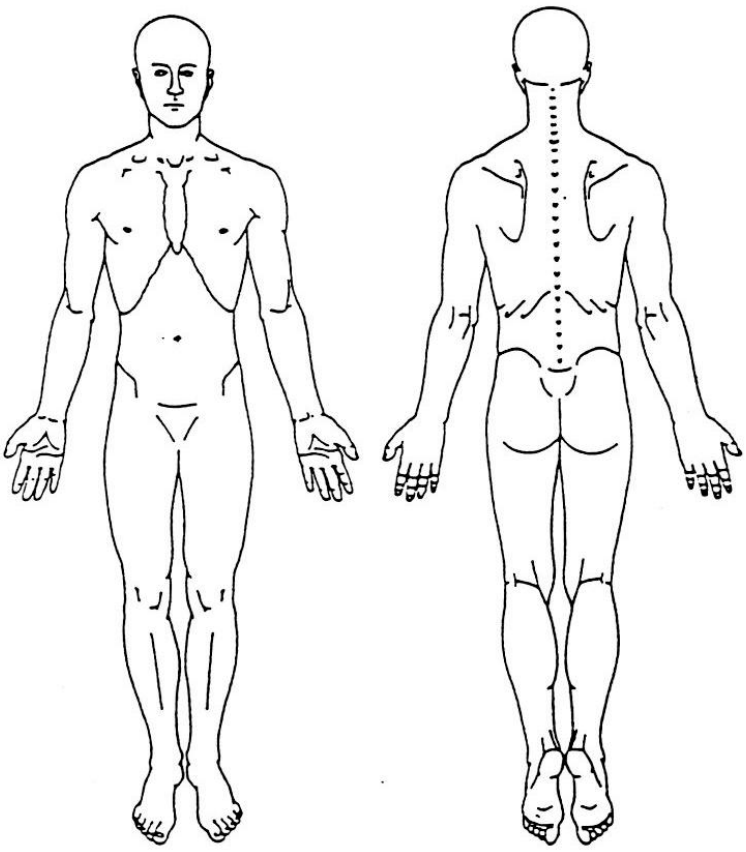
Body Diagram

Instructions:

On the body diagram below, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition,



Indicate on the line below how you would describe your present pain by placing a mark on the line between the two extremes of experiencing no pain at all and experiencing the worst pain you have ever felt.

No Pain — Worst Pain Possible