



## 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: \_\_\_\_\_



## *THE PHYSICAL THERAPY ZONE*

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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 INITIATION 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:

<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Asthma/Breathing Difficulty	<input type="checkbox"/> Hepatitis/Liver Disease	<input type="checkbox"/> Depression
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Anemia
<input type="checkbox"/> Diabetes (I or II)	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Thyroid Condition	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Heart Attack or Stroke	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Neurological Condition	<input type="checkbox"/> Chronic Infec
<input type="checkbox"/> Arthritis (Osteo / Rheum)	<input type="checkbox"/> Migraines/Headaches	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Lupus
<input type="checkbox"/> Kidney/Renal Disease	<input type="checkbox"/> Dizzy/Vertigo	<input type="checkbox"/> Drug or Alcohol Abuse	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Cancer (Type _____; Location(s) _____; Year _____; Status _____)			
<input type="checkbox"/> 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 COMPLETETE AND TRUE. IF MY MEDICAL/HEALTH STATUS CHANGES, I WILL INFORM THE PHYSICAL THERAPY ZONE IMMEDIATELY.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



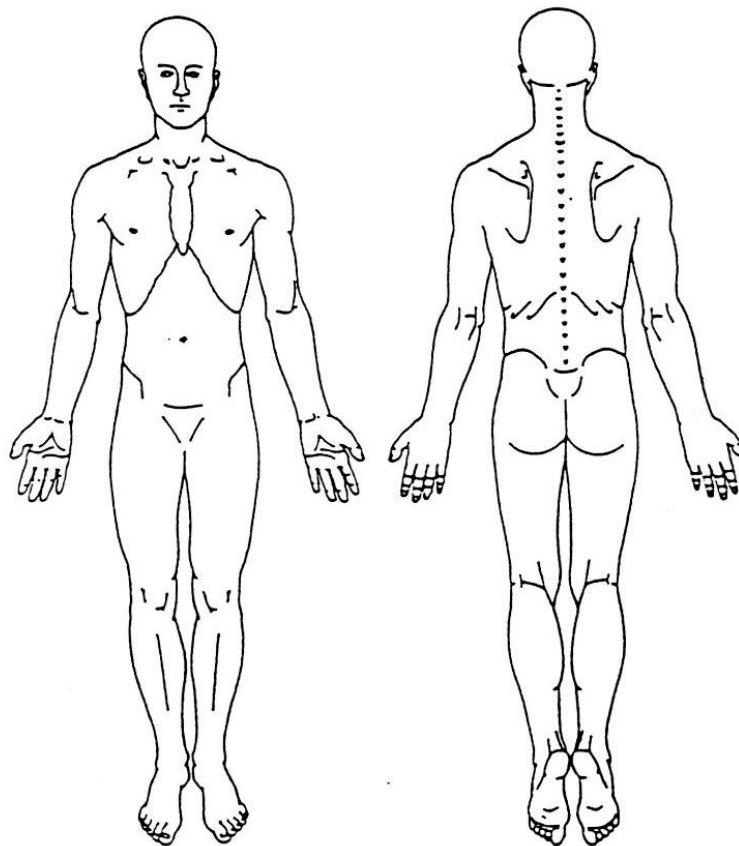
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### Body Diagram

#### 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.

