MEDCALF & SCHOMMER
PHYSICAL THERAPY

Patient Information & History

Diagnosis/ Area to be treated:

_____

Date of Onset_____

Admitting MD:_____

Family MD:_____

Language_____

Patient's Name: _____

Age:_____ **Date of Birth**:_____ **Soc. Sec. No**._____

Male _____ Female _____ Married _____ Single _____ Divorced ____ Widow ____

Patient Address: _____ Phone Number: _____

City/State/Zip Code: _____ Cell Number:_____

Email: _____ Appointment reminders via Text message: Y____N___

Patient's Job Title: _____

Patient's Employer:_____**Employer Phone**:_____

Employer Address:_____**City/State/Zip Code**:_____

In case of emergency contact:_____**Phone**_____

Address:_____**Relationship**_____

If patient is under 18 please complete:

Guardian/Responsible Party:_____
Guardian Date of Birth:_____**Guardian Soc. Sec. No**:_____**Phone:**_____
Guardian's Job Title:_____
Guardian's Employer:_____**Employer Phone:**_____
Guardian's Employer Address:_____**City/State/Zip**_____

Have you had previous therapy for your present condition for which you are to receive treatment here?

If yes, where:_____**When**:_____

Please read and sign below:
This information is complete and correct to the best of my knowledge. I hereby authorize **Medcalf and Schommer Physical Therapy** to furnish the insurance company, and/or others authorized by law, with full information regarding treatment when so requested. I hereby authorize my insurance company to pay directly to **Medcalf and Schommer Physical Therapy** medical benefits otherwise payable to me and I will be responsible to said **Medcalf and Schommer Physical Therapy** for all expenses incidental to treatment rendered not paid under this plan.

By signing below, the undersigned or their representative acknowledge that they have received a copy of the Notice of Privacy Practices.

Patient Signature:_____Date:_____

If a minor, Guardian Signature:_____Relationship:_____

Witness:_____Time:_____Date_____

Medical Information and History

Work related injury? Yes_____ No_____ Are you currently working? Yes_____ No_____

Full time:_____**Part time**_____**Modified Work Duty**_____

Motor Vehicle Accident? Yes_____ No_____ Date of Accident: _____

Sports Injury?: Yes_____No_____ Date of Injury:_____**Sport:**_____

Other:_____

_____

Brief Description of Current Symptoms:_____

What type of testing have you received for this injury:

X Ray_____MRI_____CT Scan_____Bone Scan_____ Results_____

Have you had physical therapy within the last calendar year? Yes_____No_____

If YES, was it for your current condition? Yes_____No_____Location of previous therapy:_____

Approximately how many physical therapy treatments have you received this calendar year?_____

Circle to indicated if you have had any of the following:

Diabetes	YES	NO	Hepatitis	YES	NO
Chest Pain	YES	NO	Metal Implants	YES	NO
Heart Disease	YES	NO	Fractures	YES	NO
Stroke	YES	NO	Skin Allergies	YES	NO
Seziures	YES	NO	Nausea/ Vomiting	YES	NO
Dizziness	YES	NO	Asthma	YES	NO
Headaches	YES	NO	Hypoglycemia	YES	NO
Pacemaker	YES	NO	Bladder Problems	YES	NO
Kidney Problems	YES	NO	Tumors	YES	NO
Cancer	YES	NO	Anxiety	YES	NO
Arthritus	YES	NO	Foot or leg pain	YES	NO
AIDS/HIV	YES	NO	Sprains/Strains	YES	NO
Latex Sesitivity	YES	NO	Are you pregnant?	YES	NO