HAND & ORTHOPEDIC PHYSICAL THERAPY SPECIALISTS

PATIENT INFORMATION *(Please print clearly)*

Patient's Name: _____

Date of Birth: ____/____/_____ Age: _____ Sex: Male Female Marital Status: Single Married Other

Address: _____Apt#: _____ City: _____State:_____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Employer Name: _____ Full Time Part Time Retired Student

Spouse's Name: _____ Spouse's Birthdate: ____/____/_____

Spouse's Employer: _____ Spouse's Work Phone: _____

Emergency Contact: (*not living with you*) _____Phone: _____

REFERRAL AND INJURY INFORMATION

► ***Please note that Medicare patients must provide a prescription from a doctor to receive therapy*** ◄

Referring Physician: _____

Injury or condition for which you are seeking treatment: _____

_____ Onset of Symptoms: ____ /____ /_____

Primary area of body for treatment: _____ Surgery date if any: ____/____/_____

Secondary area of body for treatment: _____ Surgery date if any: ____/____/_____

Additional areas of concern: _____

ADDITIONAL CARE

Have you received Home Health Care of any kind in the past 60 days? Yes No

If yes, please provide the name and phone number of the Home Health Agency _____

_____

Have you received physical or occupational therapy previously this year? Yes No How many visits? _____

_____

IF TREATMENT IS FOR A MINOR, PLEASE COMPLETE THE BACK OF THIS PAGE

RESPONSIBLE PARTY INFORMATION *(Required if patient is a minor)*

Responsible Party Name: _____

Date of Birth: ____/____/_____ Age: _____ Sex: Male Female Marital Status: Single Married Other

Address: _____Apt#: _____ City: _____State:_____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Employer Name: _____Full Time Part Time Retired Student

CONSENT TO TREAMENT OF MINOR CHILD

I _____, am the parent/legal guardian of_____ who is currently a minor, whose date of birth is ___/___/_____. I hereby authorize Hand & Orthopedic Physical Therapy Specialists to provide physical/occupational services as may be considered necessary or appropriate under the circumstances. I further understand that once my child reaches the age of majority, my consent for treatment is no longer required.

Signature of Parent/Legal Guardian: _____ Date: ____/____/_____

Parent of Guardian Emergency: (Home) _____ (Cell) _____

SURGICAL/HEALTH HISTORY

#1. Please list any surgeries and the approximate year you had them: **None**

Surgery:	Date:
_____	_____
_____	_____
_____	_____
_____	_____

#2. Do you have any allergies to medications, latex or adhesive? _____

Do you have a pacemaker or internal defibrillator? Yes No

Have you fallen in the last 12 months? Yes No

Did the fall result in an injury or hospitalization? Yes No

#3. Please list all current medications and the condition they are treating. This includes vitamins and supplements. If you have a current list prepared please provide it to the reception staff and skip this section:

None **List Provided**

Medication:	Dosage:	Reason:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please continue on back if necessary.