PERSONAL INFORMATION: Name_____ Height _____ Weight _____

Are you currently under any restrictions from your doctor? Yes _____ No _____

If so, why?_____

CURRENT HISTORY:

What is your main problem or issue? _____

Date of injury _____ Date of surgery _____ Date of next doctor visit _____

How did it start? Circle one: Accident Work Overuse Sports Injury Surgery Unknown

Other _____

Rate the current level of your pain ranging from when you are at your best and worse (circle best and worse)

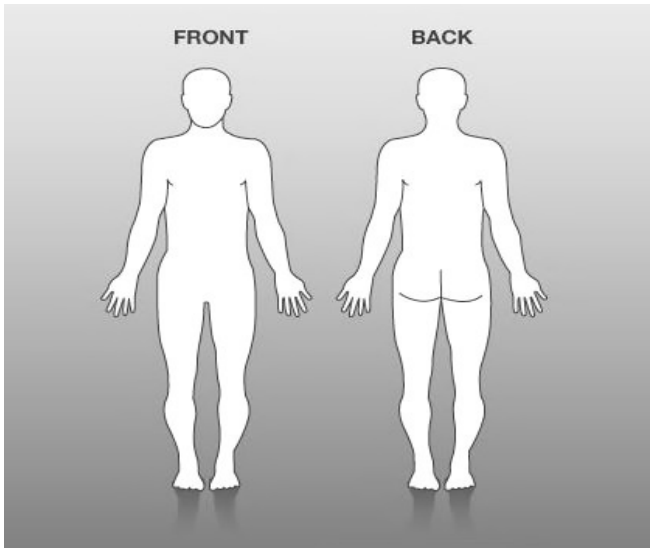
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Type of pain (circle all that apply) Constant Intermittent Sharp Dull Throbbing Burning

Any numbness, tingling, or impaired sensation? Yes_____ No _____

Is it worse in the AM _____ PM _____

On the diagram to the right, circle areas of pain/soreness



What makes your symptoms better?

_____

What makes your symptoms worse?

_____

Current level of activity 0% = bedridden 100% = able to perform all pre-injury activities

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Medical History: Circle any of the conditions below you have experienced:

Musculoskeletal

Carpal Tunnel Syndrome
Fibromyalgia
Osteoarthritis
Rheumatoid Arthritis
Sciatica
Spinal Dysfunction
Sprains/Strains
Tendonitis
Thoracic Outlet Syndrome
TMJ dysfunction

Neurological

Headaches
Multiple Sclerosis
Numbness/tingling
Parkinson's Disease
Peripheral Neuropathy
Post-Polio Syndrome
Seizures
Shingles
Stroke

Circulatory

Aneurysm
Clotting Disorder
Diabetes Type 1/Type 2
Heart Attack
Heart Disease
High Blood Pressure
Pacemaker
Peripheral Artery Disease
Varicose Veins

Lymph/Immune

AIDS/HIV
Chronic Fatigue Syndrome
Edema
Hodgkins' Disease
Lymphoma
Lupus

Integumentary

Boils
Eczema
Fungal Infection
Skin Cancer
Warts

Miscellaneous

Allergies
Cancer (other than above)
Changes in Bowel Habits
Changes in Bladder Habits
Dizziness/Fainting
Fever/Chills/Night Sweats
Mental Disorder
Mental Implants
Serious Personal Injuries
Severe Night Pain
Unexplained Weight Loss

Respiratory

Asthma
COPT
Emphysema
Tuberculosis

Digestive

Diverticulitis
Gallstones
Heartburn
Hepatitis
Irritable Bowel Syndrome
Ulcerative Colitis

List any significant operations and past medical history:

_____

_____

How is your general health? Poor Fair Good Excellent

List any implants _____

List current medications (or bring copy) _____

List any known drug allergies _____

Is there any chance that you are pregnant? Yes No N/A

Since the onset of this problem, have you had any of the following interventions? (circle)

Surgery MRI CT Scan X Rays Injections Nerve Blocks Bone Scan

Blood Tests Massage Chiropractic Physical Therapy Acupuncture Other

Patient's Name: _____

Authorization for Payment

I certify that the payment information given by me in applying for payment is correct. I authorize the release of all medical records to act on this request. I request that payment of authorized benefits from Medicare or other responsible payor be made in my behalf to Essex Physical Therapy, Inc. I understand that I am responsible for all amounts not paid by my insurance including, but not limited to, co-payments. If I am a Private Pay patient, I agree to pay for all services rendered by Essex Physical Therapy, Inc.

If Medicare is my primary insurance, I understand that I must follow up with my referring physician once every 60 days from the date of my initial physical therapy evaluation.

Authorization for Release of Information

I acknowledge the receipt of the Notice of Privacy Practices and was given an opportunity to ask questions. I understand that Essex Physical Therapy may use or disclose protected health information about me to carry out treatment, payment, or other health care operations. I authorize and give my permission to Essex Physical Therapy to release and/or receive any of my past and/or current medical information that is necessary for the coordination and continuation of my care. Further, this authorization and release applies to the furnishing of any and all information required to establish my claim for benefits with my insurance company or any government agency from which I claim benefits in payment of my bills from Essex Physical Therapy. I have reviewed the HIPPA Notice and I am aware of the posted notice in the clinic. This authorization will be considered ongoing and effective unless it is specifically revoked in writing by me or my legal representative. I hereby give my permission for the review of my medical record by any of the clinic's regulatory bodies.

Consent for Treatment

I hereby give my permission for the authorized personnel of Essex Physical Therapy to perform all necessary procedures and treatments as prescribed by my physician. I am aware that I can refuse treatment or terminate services at any time.

Cancellation/No Show

Because we offer one-on-one patient care and reserve time specifically for you we have a 24 hour cancellation policy. Failure to show and appointments cancelled or rescheduled within 24 hours of your scheduled appointment may result in a $50 charge billed to you. If you fail to show or cancel without proper notification for 2 or more appointments we may consider not rescheduling you at this office.

Payment Terms

Essex Physical Therapy, Inc. bills are due upon receipt. I agree that any charges billed to me that remain unpaid 30 days from the date billed shall incur a $100 late fee and accrue interest at 12% per annum until paid in full. In the event Essex Physical Therapy, Inc. initiates collection proceedings regarding any of my unpaid charges, I agree to pay all collection costs associated therewith, including reasonable attorney's fees.

Signature: _____ Date: _____

Signature of Guarantor or Power of Attorney (if applicable): _____

Date _____

Referring Physician: _____ Family Physician _____

How did you hear about our facility? _____

Diagnosis/Chief Complaint _____

Have you had prior physical therapy this calendar year? _____yes _____no

Patient Name _____
Last First MI Preferred name

Physical Address _____

Mailing Address_____

_____

Home Phone _____ Cell Phone _____ Work Phone _____

Date of Birth _____ Age _____ - _____Male _____Female

Social Security Number _____

Marital Status _____ Married _____Single _____Divorced _____Widowed

Name of Spouse _____

Emergency Contact: _____ Phone # _____ Relation _____

Primary Insurance _____

Primary Card Holder Name _____ Relation _____

Date of Birth _____ SSN _____

Secondary Insurance: _____

If different card holder - Name _____ DOB _____

Employer _____ Occupation _____

Employer Address _____

Employer Phone _____