



PATIENT PERSONAL AND MEDICAL HISTORY

NAME _____
FIRST MIDDLE INITIAL LAST

PERMANENT ADDRESS _____
 CITY _____ STATE _____ ZIP _____
 PHONE # (HOME) _____ (WORK) _____
 (CELL/VOICE MAIL) _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____
 SEX _____ AGE _____ WEIGHT _____ HEIGHT _____

PROFESSIONAL HISTORY:

OCCUPATION _____ EMPLOYER _____

EMPLOYER'S ADDRESS _____

EMPLOYER'S CONTACT PERSON _____

EMPLOYER'S PHONE & FAX _____

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY _____
 POLICY# _____
 GROUP# _____
 SECONDARY INSURANCE COMPANY _____
 POLICY# _____
 GROUP# _____

*I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to Performing Arts Physical Therapy for services rendered. The undersigned hereby indicates that I am financially responsible for all Physical Therapy charges not covered by my insurance company or by my workman's compensation insurance carriers. In addition, I understand that Performing Arts Physical Therapy has a **24 hour notice requirement for the cancellation of all appointments.** Should I fail to give adequate 24 hour notice, I agree to pay the charges for the missed visit.*

 PATIENT'S SIGNATURE

 DATE

MEDICAL HISTORY:

DO YOU SMOKE? _____ AMOUNT? _____ DRINK ALCOHOL? _____ AMOUNT? _____
CURRENT MEDICATIONS _____ ALLERGIES _____
EATING HABITS (VEGETARIAN, ETC.) _____

MENSTRUAL HISTORY:

AGE ONSET _____ DATE OF LAST PERIOD _____
REGULAR _____ IRREGULAR _____
AMENORRHEA _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? PLEASE CHECK ALL THAT APPLY.

RHEUMATOID ARTHRITIS: DIABETES: ANEMIA:
HYPERTENSION: EPILEPSY: PREGNANCY:
WEIGHT GAIN: WEIGHT LOSS: ASTHMA:
HEART TROUBLE: DIZZINESS: OTHER:

DATE OF INJURY

REFERRING PHYSICIAN _____
IF OTHER THAN DOCTOR WHO REFERRED YOU TO US? _____

DIAGNOSIS _____

DID YOU HAVE ANY DIAGNOSTIC TESTS (MRI, X-RAY, ETC.)?

IS THIS A WORK RELATED INJURY? _____ ARE YOU IN PAIN NOW?

DO YOU USE ASSISTIVE DEVICES (I.E. ORTHOTICS, BRACES, ETC.)?

ARE YOU CURRENTLY UNDER A PRESCRIPTION OR THERAPY ELSEWHERE FOR THIS INJURY? _____ DESCRIBE THE INJURY AND HOW IT OCCURRED

IF APPLICABLE:

TYPE OF PERFORMANCE TRAINING? _____

AGE BEGAN _____ AGE BEGAN POINTE WORK? _____

YEARS OF PROFESSIONAL EXPERIENCE _____ ARE YOU PERFORMING NOW? _____

OF HOURS OF CLASS/REHEARSAL/PERFORMANCE PER DAY? _____

DO YOU EXERCISE REGULARLY? YES NO

AMOUNT (HOURS PER WEEK) _____