Patient Information

Patient Name:_____ Sex: Male Female

Date of Birth:_____ Age:_____ Social Security #:_____ Marital Status: _____

Address:_____ City, State, Zip:_____

Phone: Cell #:_____ Home #:_____Work #:_____

Primary Contact Phone #: ❍Cell ❍Home ❍Work *Primary Email:_____

*Your email is safe with us. We email health tips to support your care, important clinic updates and/or special events.

Occupation:_____ Employer:_____#Hours/Week_____

Employer Address, City, State:_____

How did you hear about our office? *Previous PT Patient Previous Massage Client Google Social Media Website Email Newsletter Free Class Drove By/Saw Sign Event_____ Spouse/Friend: Name_____ Physician_____ Other_____

Emergency Contact:_____ Phone:_____Relationship:_____

Do you have a Primary Care Physician? No Yes Name:_____

Address or Clinic Location of Primary Care Physician:_____

Name of Insurance Plan: _____

Chief Complaints/Symptoms:

What are your Chief Complaints / Symptoms?_____

When did the most recent episode of symptoms start?_____

Is this the result of a recent injury? No Yes Describe:_____

Rate the severity of symptoms on a scale from 1 (least) to 10 (severe) at Rest:_____ with Activity:_____

Quality of Symptoms: Sharp Dull Burning Tingling Cramping Aching _____

Do your symptoms radiate? No Yes Where:_____

When do you notice your symptoms? ❍work ❍sleep ❍daily routine ❍recreation ❍sitting ❍standing ❍walking ❍bending

Other:_____

Other physicians who have treated this condition: None _____

Treatments you've had for this condition: None Medical Surgery Physical Therapy Chiropractic Massage Medication

_____

Tests you've had for this condition: None X-rays MRI CT Scan Other_____

Health History:

Vitamins/Supplements:_____

Smoking: No Yes Packs/Day_____ Exercise: Type/Frequency:_____

Coffee/Caffeine: No Yes Cups/Day_____ Soda: No Yes Cans/Week_____ Alcohol: No Yes Drinks/Week_____

Stress Level: Low Moderate High_____

Work Activity Involves (circle): Sitting Standing Light Labor Heavy Labor Traveling Other:_____

Are you Right or Left Handed? Right Left **Females: Are you pregnant?** No Not Sure Yes Due Date:_____

List all past **Injuries or Accidents** (Year):_____

_____

Medical History

Existing or Relevant Previous Conditions

Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA (skin infection staph)	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinson's	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High/Low blood pressure	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High Cholestero	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No		

Describe any other conditions

If "Yes" to any of the above, please **explain** and **give approximate dates**.

Describe any **other conditions not listed above**.

Fall History

Injury as a result of a fall in the past year? ◯ No ◯ Yes _____

Two or more falls in the last year? ◯ No ◯ Yes_____

Surgical History **Month / Day / Year**

Body Region:_____Surgery Type:_____Date:_____

Body Region:_____Surgery Type:_____Date:_____

Body Region:_____Surgery Type:_____Date:_____

Body Region:_____Surgery Type:_____Date:_____

Current Medications ◯ currently not taking any medications

Drug:_____Dosage:_____Frequency:_____Route:_____Reason Taking:_____

Drug:_____Dosage:_____Frequency:_____Route:_____Reason Taking:_____

Drug:_____Dosage:_____Frequency:_____Route:_____Reason Taking:_____

Drug:_____Dosage:_____Frequency:_____Route:_____Reason Taking:_____

Review of Systems: Have you experienced any of the following in the **last few months?**

Please circle and detail below. If you have no complaint in a category please circle "NONE".

General: Fever Chills Swollen glands Loss of memory Weakness Aches/pains Weight loss/gain Cancer NONE

Headaches: Tension Migraines Premenstrual Other Frequency:_____ NONE

Eyes: Glasses/contacts Double vision Blurry vision Eye pain Glaucoma cataracts NONE

Ear/Nose/Throat: ear pain hearing loss ringing in ears nosebleeds sinus problems tooth pain hoarseness NONE

Skin: Rashes Changing moles Change in skin Other lesions Itchy skin Eczema Numbness NONE

Cardio: Irregular beat/palpitations Chest pain High blood pressure Pacemaker Heart attack date:_____ NONE

Lungs: Cough Cough up blood Wheezing Asthma Shortness of breath Sleep apnea NONE

GI: Poor appetite Indigestion/heartburn Nausea Vomiting blood Abdominal pain/cramps Constipation

Diarrhea Change in bowel habits Rectal bleeding Liver disease Hepatitis Irritable bowel NONE

GU/GYN: Urinate at night more than once Blood in urine Burning or pain when urinating

Problems passing urine Problems controlling urine Incontinence Menstrual problems NONE

Neuro: Weakness in extremity R L_____ Tingling or numbness Radiating pain Balance problems

Sciatica dizziness Fainting spells Speech problems Seizures Stroke Head injury Concussion NONE

Musculoskeletal: Joint pain Swelling Muscle spasms Back or neck pain Sprain/strain fracture NONE

Hemo: Bleed or bruise easily Varicose veins Blood clots Lymph node pain/enlargement NONE

Endocrine: Constant thirst Always cold Always warm Very sluggish or tired Hot flashes NONE

Family History:

Is there a history of any of the following conditions in your family?

Diabetes Heart Attack Stroke Cancer Kidney Problems Arthritis Scoliosis Migraines Thyroid Disease

High Blood Pressure High Cholesterol Other Inherited Diseases:_____

_____

CONSENT FOR DISCLOSURE OF INFORMATION:

Our clinic has always been very protective and respectful of your personal information. Under the HIPAA Privacy Act we have adopted additional guidelines to ensure the proper use, confidentiality and disclosure of your health information.

⇨ I give the clinic permission to leave a message on my voice mail / answering machine. ◯ No ◯ Yes
Note: This statement applies to phone calls outside our usual appointment reminder calls.

⇨ I give the clinic permission to discuss my medical condition with another person. ◯ No ◯ Yes

If yes, please specify names. Parents: _____ Spouse:_____

Other:_____

X_____ Date:_____

Signature of Patient, Parent or Guardian if under 18 years old

Consent for Treatment:

I hereby give consent to the healthcare providers of Wellspring Health Center, PLLC / Sports & Family Wellness, PLLC to render such care and treatment as might be required by my condition. Such care may include, but is not limited to consultations, examinations, digital x-rays, rehabilitative physical therapy, medical treatment, massage, wellness or maintenance care.

X_____ Date:_____

Signature of Patient, Parent or Guardian if under 18 years old

HIPAA Privacy Policies: Consent for Use and Disclosure of Health Information

I acknowledge that I have been made aware of the clinic's privacy policies and may request a copy at any time. The policies are available in our reception area and on our website at www.wellspringhopkins.com.

X_____ Date:_____

Signature of Patient, Parent or Guardian if under 18 years old

Payment Policy

We will file claims with contracted and approved insurance plans as a courtesy. The clinic has the right to not accept non-contracted insurance plans at its discretion and in these cases; charges for services rendered are to be paid at the time of service, unless other arrangements have been made in advance. I understand that if I have not listed any insurance plan that I am responsible for the full amount of the visit unless other arrangements have been made in advance. Please note that affordable payment options and financial hardship plans are available if needed.

I understand that I am financially responsible for all charges whether or not paid by insurance, unless other arrangements have been made in advance. Any unpaid patient balance will accrue a 1 ½% monthly billing charge after 90 days. Any collection fees, attorney fees, or returned check fees are the responsibility of the adult person(s) named on the account.

Assignment of Insurance Benefits

I certify that I or my dependents have insurance through the insurance company information that I have provided and assign directly to Wellspring Health Center, PLLC / Sports & Family Wellness, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

In the event that my insurance company forwards payment directly to me, instead of Wellspring Health Center, PLLC / Sports & Family Wellness PLLC, I will immediately deliver said payment to Wellspring Health Center, PLLC / Sports & Family Wellness, PLLC.

I also verify that all the information contained on the history forms is true and correct to the best of my knowledge and belief. I authorize Wellspring Health Center, PLLC / Sports & Family Wellness, PLLC to release my complete records to its business management company and/or to my insurance carrier(s) and or agents to secure payment of benefits; I also authorize Wellspring Health Center, PLLC / Sports & Family Wellness, PLLC designation of representation for insurance claims appeals.

Release of Records

I authorize the release of my complete records to or from other physicians or medical facilities that may be pertinent and necessary to my care and treatment.

Print Patient Name:_____

X_____ Date:_____

Signature of Patient, Parent or Guardian if under 18 years old