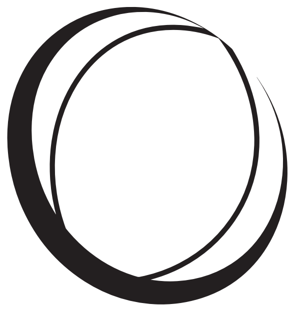


PTIMAL
PHYSICAL THERAPY

(1)Patient Info:
First name: ______________________________
Middle initial: ______ Last name: ____________
Gender: ☐ Male ☐ Female
Date of birth (MM/DD/YYYY): ____/____/_____
Social Security # : ________-_____-___________
Please circle phone type: Home | Cell
Primary Phone: (____) _______-___________
E-mail:______________________________
Would you like to receive appointment reminders?
☐ No
☐ Yes → ☐ Email ☐ Phone call ☐ Text Message
Marital status:
☐ Single ☐ Married ☐ Divorced
Employer name: ____________________________
____

(2)Billing Address:
Street: __________________________________
____
City: _______________State:______________
Zip code: ________________________________

(3)Emergency Contact Information:
Name: __________________________________
Primary phone: ____________________________
Relation to patient: _________________________

(4)Insurance:
Are you utilizing insurance? ☐ Yes ☐ No
Are you the account holder? ☐ Yes ☐ No
Are you on someone else's insurance? ☐ Yes ☐ No
If yes, please provide the following information:
Name: _________________________________
Date of birth: ____/____/______
Address: _______________________________

(5)Worker's Compensation Patients:
Claim number: _________________________
Employer: _____________________________
Employer Address
Street: ______________________________
____
City: _______________State:____________
Zip: ________________________________
Phone Number: _________________________
Date of injury associated with claim: _________

(6)Reason(s) for Treatment:
Area/Part of body: __________________________
Cause of injury or pain: ______________________
Date of injury: ______________________________

(7)Referring Physician:
____

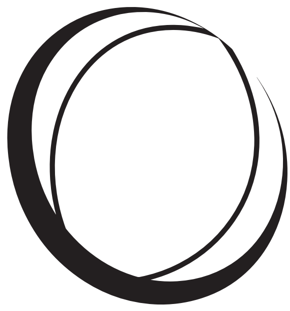
(8)Medical History:

☐ Arthritis	☐ Osteoporosis
☐ Osteoarthritis	☐ Diabetes (Type II)
☐ Rheumatoid Arthritis	☐ High blood pressure
☐ Hepatitis	☐ HIV / Aids
☐ MRSA	☐ Head Injury/TBI
☐ Concussion	☐ Asthma
☐ Stroke	☐ Cardiovascular (heart) disease

Other past medical history:
____
____
____
Are you or could you be pregnant?
☐ Yes ☐ No
History of cancer?
☐ Yes ☐ No
Year(s):_________________________________
Type(s):_________________________________

(9)Surgical History:
____
____
____

(10)Medications/Allergies:
Current medication(s): ______________________
____
____
Please list all known allergies: _______________
____



PTIMAL

PHYSICAL THERAPY

I, ____
have been offered or received a copy of the “Notice of Privacy Practices” from Optimal Physical Therapy, LLC or a designated affiliate.

I acknowledge by signing this form I am stating that I am aware of and understand the content of the privacy practices.

Signature: ____

Date: ____________________

Medicare Intake form

Name:____________________________ Date:____/______/________

Falls History

Falls History			
Have you had any falls within the last year?	No	Yes	If yes, how many?
Have you had any Injuries related to a fall:			
Pain Location:			
Pain Description (ie.Burning,throbbing,shooting,sharp):			

Please rate your pain levels by circling a number to rate your pain:

Pain Scale:	0 = No pain				5 = Moderate Pain				10 = Extreme Pain		
At Worst:	0	1	2	3	4	5	6	7	8	9	10
Current:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10

Medications If you already have a medication list, please bring in a copy.	**Dosage**	**Frequency**

For office use only.

Height:	Weight:	Blood Pressure:

☐ See E-Docs for Medication List