NORMAN PHYSICAL THERAPY PATIENT DATA SHEET				
First:	MI:	Last:		
Date of Birth:	Age:	Gender: Male Female		
Physical Address:		Mailing Address:		
Phone Numbers: OK To 0	Call Best Tim	ne To Call		
Home:				
Work:				
Cell:				
May we send you text messages above? Yes No	for your appo	ointment reminders to the number(s) listed		
May we send you text messages the number(s) listed above?	for Marketing Yes □ No	Materials, including Patient review requests to		
By marking "Yes" above, you und of unauthorized access to your in		text messages may NOT be secure, with a risk		
May we send you emails relating	to your care v	nderstand that email communications		
Preferred language:		_ Interpreter required?		
Date of Injury:	Refer	ring Physician:		
Injury Area:		/ork Accident: Auto Work N/A		
State Where Accident Occured:_				
Are you currently receiving or have (including any therapy, nursing, b				
Are you currently receiving or have the last 60 days?	re you receive	ed other therapy services in Yes No		
Marital Status:				
Married Single Div	vorced \[\]	Nidowed Separated Unknown		
Student Status:				
Full-Time Part-Time	None			

EMPLOYMENT STATUS				
Employment Status: Active Military Full-Time None	Part-Time Retired Self Employed			
Employer:	Occupation:			
Address:				
Phone:				
Employer: C	Occupation:			
Address:				
Phone:				
INSURANCE INFORMATION				
Primary Insurance:				
Policy Holder's Name:	Holder's Birth Date:			
Policy or Certificate #:	Group #:			
Policy Holder's Employer:				
Secondary Insurance:				
Policy Holder's Name:	Holder's Birth Date:			
Policy or Certificate #:	Group #:			
Policy Holder's Employer:				

MR #: Page: 3/4 Patient Name: How did you hear about us? **Physician** Hospital Marketing Ad - Print **Employer Cross Referral** Friend - Word of Mouth Case Manager ■ Marketing Ad - Billboard Former Patient Marketing Ad - Direct Mail - Email Attorney Adjustor Self School **Screens - Open Houses** Marketing Ad - Other ____ Specify if other: Note: Please provide us with the most updated information below. **EMERGENCY AND OTHER CONTACTS** Name Phone Work Cell Fax Туре DISCLOSURE OF MEDICAL RECORDS I authorize the following individuals to have access to my medical and billing records: Relationship Name Relationship Name

Signature of Patient

Date

PATIENT INTAKE AND CONSENT FORM

Internal Use Only:	A/C#	Name	A/C Type	Office #
CONSENT TO I consent to reha		d services at: NORMAN F	PHYSICAL THE	RAPY
_		dge and affirm that such r direct contact of a sensitiv		d related services may ials:
that I have been	ardian of a minor re	ceiving treatment hereund on the premises during an re to do so.		
•	e that: NORMAN Poss or damage to pe	HYSICAL THERAPY is neersonal valuables.	ot	Initials:
its agents, repre demand, damag accept, receive of	, discharge and acq sentatives, affiliates e, cause of action, or allow emergency	uit: NORMAN PHYSICAL s, employees, or assigns, or loss of any kind arising and or medical services i cian, physician or urgent o	of and from any out of or result ncluding but no	ing from my refusal to
I hereby assign a I also authorize i facilitate my trea	release of any medi Itment and to other	to: NORMAN PHYSICAL color records to other health third parties as necessary records of Privacy Practice.	ncare providers to process me	
not pay for the se To assist in e - Supply a insurance - Satisfy a on the da - Provide y	y that, in the event rervices I receive, I vertices I receive, I vertices I receive, I vertices I necessary informate card, driver's licentary services are rendrour insurance compour insurance	ation for accurate billing of se, employer information, nents, co-insurance, dedu	ole for payment your claim, incl and demograph ctibles, and nor tional information	uding your nic information. n-covered services
I acknowledge re	IVACY/PATIENT Beceipt of Notice of Peceipt of the Statem			Initials:
I certify that all o	f the information pro	ovided herein is true and c	orrect.	
Patient/Guardian Signature		Witness Signature		Date

Medical History Form

Patient Name:		Today's Date:			
Referring Physician:	ferring Physician: Date of Birth:			Age:	
Primary Care Physician:	rimary Care Physician: Date of Injury or C		Onset:)nset:	
Date of Next Physician Appointment:					
Reason for Therapy:		I			
Course of Indiana on Operate Assistant	Ata D. Marile D. Otha	If Other relea	aa avulain.		
Cause of Injury or Onset: ☐ Accident ☐	Auto Work Othe	r: If Other, plea	ise explain:		
Have you been hospitalized for the pres	ent condition? Te	s No If Yes	, date:		
Did you have surgery for this condition If Yes, surgery type:	? 🗌 Yes 🗌 No	If Yes, date:			
Are you currently receiving any other call f Yes, please describe:	are for the condition r	nentioned above?	□Yes □No		
Have you ever received therapy in the p	past for the condition	mentioned above? [_Yes	es, date:	
Describe previous treatment:					
Previous Treatment: ☐Successful ☐Un	successful				
Have you fallen in the last year? ☐ Yes ☐ No If Yes, how many times? If Yes, were you injured? ☐ Yes ☐ No Do you worry about falling? ☐ Yes ☐ No					
What are your personal goals/outcome	s you hope to achieve	from therapy?			
Describe your general health: Excel	lent ☐ Good ☐ Fair	☐ Poor Do yo	ou smoke or use	tobacco?	
DO YOU CURRENTLY HAVE OR HAVE A H	ISTORY OF ANY OF TH	E FOLLOWING COND	ITIONS? (check all	l that apply)	
☐ Allergies ☐ Latex ☐ Other	☐ Dizziness		☐ Kidney Problems		
☐ Anemia	☐ Epilepsy or Seizure Disorder		☐ Metal Implants		
☐ Anxiety or Panic Disorders	☐ Fainting		☐ MRSA		
☐ Arthritis ☐ OA ☐ RA	☐ Fatigue or Weak	☐ Fatigue or Weakness		☐ Multiple Sclerosis	
☐ Asthma	☐ Fever or Chills	☐ Fever or Chills		☐ Nausea / Vomiting	
☐ Use of Blood Thinners	☐ Fractures		☐ Osteoporosis		
☐ Bowel or Bladder Disorder	☐ Headaches		☐ Pacemaker		
☐ Bleeding Disorder	☐ Head Injury or Concussion		☐ Parkinson's Disease		
☐ Cancer	☐ Hearing Impairment		☐ Peripheral Vascular Disease		
☐ Chronic Cough	☐ Heart Disease or Heart Attack		☐ Respiratory or Breathing Problems		
☐ COPD	☐ Hepatitis ☐ A ☐ B ☐ C		☐ Ringing in Ears		
☐ Congestive Heart Failure	☐ Hernia		☐ Sexual Dys	sfunction	
☐ Currently Pregnant	☐ Blood Pressure	☐ High ☐ Low	☐ Skin Abnor	rmalities	
☐ Deep Vein Thrombosis (DVT)	☐ HIV or AIDS		☐ Stroke or T	'IA	
☐ Depression	☐ Hypoglycemia	☐ Hypoglycemia		☐ Thyroid Problems	
☐ Diabetes ☐ Type I ☐ Type II	☐ Hypersensitivity	Hypersensitivity to Hot or Cold		sis	
List any other medical problems and explain:					

Medical History Form

Medication List					
Name of Medication	Dosage	Frequency			
☐ Check Box if Medication List provided separately.					
1.			☐ Injection ☐ Oral ☐ Topical ☐ Other		
2.			☐ Injection ☐ Oral ☐ Topical ☐ Other		
3.			☐ Injection ☐ Oral ☐ Topical ☐ Other		
4.			☐ Injection ☐ Oral ☐ Topical ☐ Other		
5.			☐ Injection ☐ Oral ☐ Topical ☐ Other		
6.			☐ Injection ☐ Oral ☐ Topical ☐ Other		
7.			☐ Injection ☐ Oral ☐ Topical ☐ Other		
8.			☐ Injection ☐ Oral ☐ Topical ☐ Other		
9.			☐ Injection ☐ Oral ☐ Topical ☐ Other		
10.			☐ Injection ☐ Oral ☐ Topical ☐ Other		
11.			☐ Injection ☐ Oral ☐ Topical ☐ Other		
12.			☐ Injection ☐ Oral ☐ Topical ☐ Other		
Over the Counter Medications (check all that apply): Aspirin/Ibuprofen Antacids Sleeping Aids Cold Medicine: Cough Medicine Allergy Relief Laxative Diet Pills Vitamins/Herbal Supplements Other:					
Pain Scale Rate the severity of your pain by circling a box on the following scale. No Pain Worst Pain 1 2 3 4 5 6 7 8 9 10 On the Body Diagram mark where you are experiencing symptoms, right now. Use the letters below to indicate the type and location. KEY: A = Aching B = Burning N = Numbness P = Tingling S = Stabbing O = Other					
Signature of Patient:		DOB:			
Printed Name of Patient:		Date:			