Patient Name:

Patient Information (Please Print)

Name _____ DOB _____

Mailing Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Sex _____ Email _____ Work Phone _____

Employer _____ Occupation _____

May we contact you in regards to treatment at ☐ home phone ☐ cell phone ☐ email ☐ other: _____

Would you like to receive healthcare information from our office via email? Please circle YES/NO

Preferred Language: (Circle one): English Spanish Other: _____ (please specify)

Responsible Party, if patient is a minor (adult signing this form)

Name _____ Employer _____

DOB _____

Insurance Information **complete this information only if we will not receive a copy of your insurance card**

Primary Insurance Name: _____ **Secondary Insurance Name:** _____

*ID# *Group# *ID# *Group#

Policyholder Information (complete only if not self)

Spouse or Responsible Party Name _____ DOB _____

Mailing Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Relationship _____ Policy Holder Yes / No _____

Employer _____ Work Phone _____

*****Workers' Compensation Insurance ONLY*****

Insurance Carrier _____

Claims Rep _____ Phone Number _____

Claim Number _____ Date of Injury _____

Work Address _____ City _____ State _____ Zip _____

Emergency Information

Contact _____ Relationship _____ Phone _____

Address _____ City _____ State _____ Zip _____

Referred By (please list name):

☐ Physician: _____ ☐ Friend/Family: _____ ☐ Other: _____

AUTHORIZATION: I hereby authorize The Body Shop to furnish information requested to insurance carriers concerning my illness. I hereby irrevocably assign to The Body shop all payments for medical services rendered. I understand that I am financially responsible for all charges, whether or not covered by insurance. I authorize any holder of medical information about me to release to The Body Shop that information needed during the course of my treatment. By signing below I have received and agree to the terms of The Body Shop's Financial Policy, Notice of Privacy Practices and Patient Consent Form. The above information is true to the best of my knowledge. I have been informed of my plan of care and give consent for physical therapy treatment and I authorize that my insurance benefits be paid directly to the physical therapist. I understand that I am financially responsible for any balance. I also authorize The Body Shop PT Clinic or insurance company to release any information required to process my claims.

Patient Signature _____ Date _____

Patient Name:

Patient Information

Height:_____ Weight:_____

Have you been here in the past 3 years? _____ Hand Dominance: R / L

Reason for visit: _____

Primary Care Physician: _____

Please list all known allergies: _____

Please list all relevant past medical history (fractures, hospitalizations, injuries, etc.) with approximate dates:

_____

_____

Please list all current medications, herbals, and vitamins you are taking. Please include over the counter medication as well (use reverse if needed).

1. _____ 2. _____ 3. _____ 4. _____

♦ SOCIAL HISTORY ♦

Marital Status:_____ Number of Children:_____

Do you use tobacco now? _____ In the past?_____ Avg.daily amount: _____ How Long?_____

Do you drink alcoholic beverages?_____ In the past?_____ Avg.Weekly amount: _____ How Long?_____

Are you or could you possibly be pregnant now? _____

♦ REVIEW OF SYSTEMS ♦

Please circle level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain

Please circle your areas of pain on the diagram below: