Physical Therapy Services of Brooksville, Inc.
Patient Information Sheet
(Please Print)

Date: ________________

Patient Name: ____ Birth Date:_________________

Patient Mailing Address: ____

City:______________________________ State: ______ Zip:___________

Phone Number: (___)____________________ Cell Number: (___)__________________________

S.S. Number: ____________________ Email Address: _________________________________

Sex: M____ F____ Marital Status: M____ S____ D____ W____ Other_______________________

How did you hear about us?____

Guarantor Name: _____________________________________ Birth Date: _______________

Guarantor Address: ____

City:____________________________ State: ______ Zip:___________

Phone Number: (___)________________ S.S. Number: _________________ Sex: M____ F____

IN CASE OF EMERGENCY PLEASE LIST NAME AND PHONE NUMBER OF 2 PEOPLE WE MAY CONTACT:

Name: ________________________ Relationship __________ Phone Number:________________

Name: ________________________ Relationship __________ Phone Number:________________

Accident Related? Yes___ No___ Type: Work___ Auto___ Other___ Date of Injury:______________
Accident Details:____
____
____

***Employer information must be completed for Workman's Compensation:**
Employer:____________________________________ Phone Number:_____________________

Address:____

Insurance Information

Primary Insurance Company:____

Policy Holder Name: __________________ Birth Date:_____________ Relationship:_______________

Secondary Insurance Company:____

Policy Holder Name: __________________ Birth Date:_____________ Relationship:_______________

I, hereby authorize Physical Therapy Services of Brooksville, Inc. to administer services deemed advisable in treatment to physicians diagnosis. I hereby, authorize the above insurance company to pay any medical benefits to which I am entitled directly to Physical Therapy Services of Brooksville, Inc. I, hereby authorize said assignee to release all information necessary, including medical records, to secure payment. It is understood that the undersigned and patient are solely responsible for payment of patient's bill.

Patient/Guardian____ **Date:**_______________

PHYSICAL THERAPY SERVICES OF BROOKSVILLE, INC.
MEDICAL HISTORY FORM

Name: ______________________________ Diagnosis: ______________________________

Referring Physician: ______________________________ Primary Care Physician: ______________________________

Are you presently working? YES ______ NO ______ Dominant Side: RIGHT ______ LEFT ______

Have you had any type of therapy? YES _____ NO ______ Height: __________ Weight: __________

Have you had any falls in the last year? YES ______ NO ______ If so, how many? _______

Is this injury due to work? YES ______ NO ______ Is this injury auto related? YES ______ NO ______

MEDICAL PROBLEMS

☐ Pacemaker	☐ Heart/Lung Disease	☐ Hypertension	☐ Heart Attack
☐ Diabetes - Type I or II	☐ Cancer	☐ Respiratory Illness	☐ Kidney Disease
☐ Hepatitis	☐ Epilepsy	☐ Head Injury	☐ Light-headedness
☐ Rectal Pain	☐ Sciatica	☐ Endometriosis	☐ Lupus
☐ Pelvic/Vulvar Pain	☐ Bowel Problems	☐ Fibromyalgia	☐ Strokes
☐ Hip Pain	☐ Arthritis	☐ TMJ	☐ Seizures
☐ Knee Pain	☐ Osteoporosis	☐ Leg Cramps	☐ Broken Bones
☐ Back Pain	☐ Spinal Stenosis	☐ Blood Clots	☐ Any Metal Implants
☐ Neck Pain	☐ Rheumatoid Arthritis	☐ Interstitial Cystitis	☐ Currently Pregnant
☐ Ankle/Foot Pain	☐ Pelvic Inflammatory Disease	☐ Mental Disorder	☐ Infectious Disease
☐ Shoulder/Elbow/Wrist Pain	☐ Pain/Difficulty Urinating	☐ Unusual Reaction to Hot or Cold	

SURGERIES AND DATES

☐ Hysterectomy ______________________	☐ Prostate ______________________
☐ Hernia Repair ______________________	☐ Gall Bladder ______________________
☐ Orthopedic Surgery ______________________	☐ Kidney ______________________
☐ Bladder Repair ______________________	☐ Cardiac ______________________
☐ Appendectomy ______________________	☐ Other ______________________
☐ C-Section ______________________	☐ Disabled Yes No Why?______________

ALLIERGIES

MAJOR HOSPITALIZATIONS

EXPECTATIONS/GOALS FOR THERAPY

Are you aware of the Diagnosis/Prognosis? YES ______ NO ______

Do you have an Advanced Medical Directive (Living Will)? YES ______ NO ______

Would you like information about a Living Will? YES ______ NO ______

Whom may we thank for referring you? ______________________________

I have read and filled out the history questionnaire to the best of my knowledge.

Signature ______________________________ Date: ______________

Patient Communication Authorization

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made alternative means. Such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply) :

[ ] Home Telephone: ______________________
[ ] O.K. to leave a message with detailed information [ ] Leave message with call-back number ONLY

[ ] Cell Phone: ___________________________
[ ] O.K. to leave a message with detailed information [ ] Leave message with call-back number ONLY

[ ] Work Telephone: ______________________
[ ] O.K. to leave message with detailed information [ ] Leave message with call back number ONLY

[ ] Written Communication: ____
[ ] O.K. to mail to my work address [ ] O.K. to mail to my home address [ ] O.K. to fax to this number

Verbal Authorization

Verbal Authorization received to discuss protected health information of the above patient with the following next of kin:

______________________________________ ________________________
Name Relationship

______________________________________ ________________________
Name Relationship

Acknowledgment

Physical Therapy Services of Brooksville, Inc. Notice of Privacy Practices-was given to me upon signing and is also permanently posted in the lobby at each facility.

______________________________________ ________________________
Print Name Date of Birth

______________________________________ ________________________
* Signature Date

PHYSICAL THERAPY SERVICES

Of BROOKSVILLE, Inc.	Of SPRING HILL	Of SUMTER	Of SUMTER *At Langley*
20195 Cortez Blvd.	3247 Commercial Way	413 West Street	1389 Hwy. 301, Suite A
Brooksville, FL 34601	Spring Hill, FL 34606	Bushnell, FL 33513	Sumterville, FL 33585
Ph: (352) 754-4500	Ph: (352) 683-4551	Ph: (352) 569-0040	Ph: (352) 569-1088
Fax: (352) 754-9343	Fax: (352) 683-8957	Fax: (352) 569-0090	Fax: (352) 569-1090

Patient Medication List

Patient Name:______________________________________ Date: __________

Medication	Dosage	Frequency	Route
____________________	______	_________	Oral/Topical/Injection/Inhalation
____________________	______	_________	Oral/Topical/Injection/Inhalation
____________________	______	_________	Oral/Topical/Injection/Inhalation
____________________	______	_________	Oral/Topical/Injection/Inhalation
____________________	______	_________	Oral/Topical/Injection/Inhalation
____________________	______	_________	Oral/Topical/Injection/Inhalation
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____________________	______	_________	Oral/Topical/Injection/Inhalation