

Medical History Form-Medicare

Name: _____ Referring Physician: _____

Address: _____ City _____ State _____ Zip _____

Phone # _____ Date of Birth _____ Patient SSN _____ Sex: M F

Onset of this condition or illness: ____/____/____ Date of Last Physician Visit: ____/____/____

Were you discharged from the hospital or nursing home or home health agency within the past 30 days? Yes No

Are you seeing anyone else for treatment of this same condition? Yes No

Have you ever had this condition in the past? Yes No

Did you receive treatment at that time? Yes No

Where do you currently live Private home Apartment Group home Assisted Living Other

Who do you currently live with? Alone Spouse/Significant other Child(ren) other relative Unrelated person(s) Other

Do you expect (intend) your living arrangements to change after the completion of treatment? Yes No

Do you use any assistive device such as cane, walker, wheelchair or tub seat? Yes No

Do you wish to use the services of a Social Worker? Yes No

At the present time would you say your health is Excellent very good good fair poor

Past History: Please check if you have or ever had one of these conditions or problems.

- Cancer
- Heart Problems
- Circulation Problems
- High Blood Pressure
- Nervous System Disease
- Cardiac Pacemaker
- Metal implants (rods, pins etc)
- Joint Replacements
- Bone Fracture
- Back Problem
- Kidney Disease
- Stroke
- Muscular disease
- Lung Disease
- Arthritis
- Diabetes
- Hepatitis
- Epilepsy or Seizures
- Asthma
- Depression
- Neck Problem
- Other: _____

<u>Therapist Only</u>

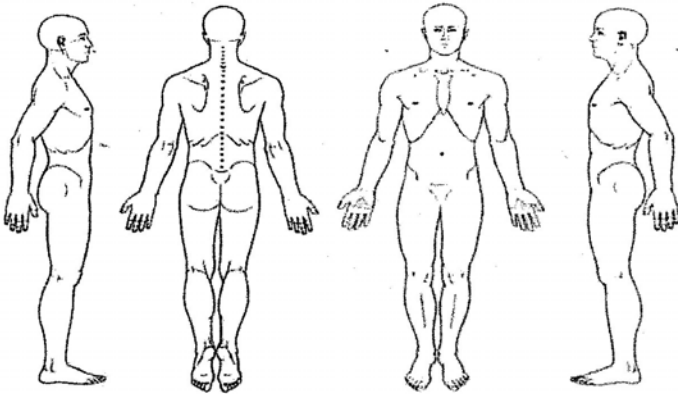
For Therapist Use Only

Please list any surgeries that you have had including date if known _____

Please list any prescription or non prescription medications that you are currently taking _____

Please briefly describe the problem(s) for which you are seeking treatment _____

When did this problem start? _____



Please mark on the picture anyplace that you are having pain, tingling or numbness

What is your current pain level?:

0 _____ 5 _____ 10
No Pain Worst Possible

Person to contact in case of an emergency: _____ Phone _____

Consent to Release

I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Jaworski Physical Therapy, Inc. ("The Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the regulations. I am aware that The Practice maintains a "Privacy Notice" which sets forth the types of uses and disclosures that The Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which The Practice will make such use or disclosure. By signing this Consent, I understand and acknowledge that I have reviewed the "Privacy Notice" which is attached before signing this Consent.

General: I hereby assign all medical benefits to include Major Medical, Medicare, Private Insurance and other sponsored programs and health plans and I authorize payment of medical benefits to Jaworski Physical Therapy, Inc. I understand that I am financially responsible for all charges whether or not paid by said insurance and I hereby authorize said assignee to release all information necessary to secure payment of said benefits. The assignment will remain in effect until revoked by me in writing.

Authorization for Treatment: I know that I am suffering from a condition(s) requiring physical/occupational/speech therapy. I hereby voluntarily consent to such treatment and procedures as prescribed by my physician and to be performed by employees of Jaworski Physical Therapy, Inc.

Permission to take Photograph: I hereby consent or deny Jaworski Physical Therapy, Inc. to take a photograph of me only for the purpose to use in my medical chart and will not be disclosed for any other reason without additional permission from me. I do so by checking yes or no below.

____ YES ____ NO

Permission to take Photograph

Patient's signature

Signature other than patient (if patient is a minor)

Date

Relationship

Date

Witness