**Jaworski Physical Therapy, Inc.**

## Patient Medical History Form

| Name: | | SSN# | | Phone: |
|---|---|---|---|---|
| Address: | | City: | State | Zip Code |
| Date of Birth | Sex ☐ M ☐ F | Employer: | | Occupation: |
| Cardholder (if different) | | Relationship to cardholder | | Phone: |
| Address: | | City:<br>State | State | Zip Code |
| Email: | | | | |

Were you referred to this clinic by another medical provider? ☐ Yes ☐ No If yes: _____

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

Did that treatment help? ☐ Yes ☐ No

For Therapist Use Only

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: _____

For Therapist Use Only

Are you or do you think you may be pregnant? ☐ Yes ☐ No

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

_____

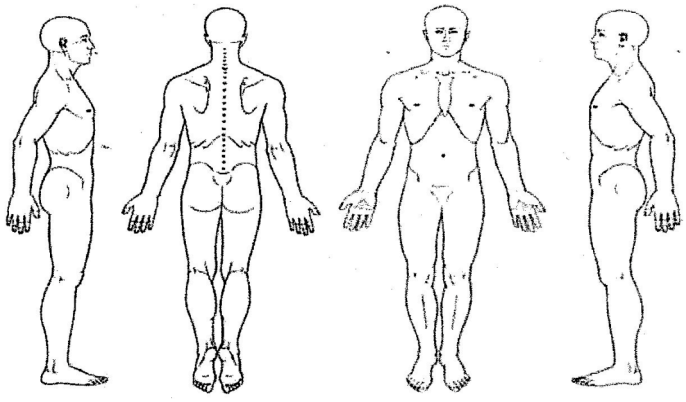
Please list any prescription or non prescription medications that your are currently taking: _____

_____

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 Possible — Worst

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

(rev 2/07)