LIVE WELL PHYSICAL THERAPY PATIENT DATA SHEET					
First:	MI:	Last:			
Date of Birth:	Age:	Gender: Male Female			
Physical Address:		Mailing Address:			
Phone Numbers:	OK To Call Best	Time To Call			
Home:					
Work:					
Cell:					
	nessages for your a No	ppointment reminders to the number(s) listed			
May we send you text r the number(s) listed ab	<u> </u>	ting Materials, including Patient review requests to			
By marking "Yes" above of unauthorized access		that text messages may NOT be secure, with a risk			
<i>J</i> .	il address below, yo	are with us? Yes No ou understand that email communications rized access to your information.			
Preferred language:		Interpreter required? Yes			
Date of Injury:	Re	eferring Physician:			
Injury Area:		or Work Accident: Auto Work N/A			
State Where Accident 0	Occured:	<u> </u>			
	•	eived Home Health Services Yes No No Irressing, etc) in the last 60 days?			
Are you currently receive the last 60 days?	/ing or have you rec	eived other therapy services in Yes No			
Marital Status:					
Married Single	e Divorced	Widowed Separated Unknown			
Student Status:					
Full-Time Pa	rt-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

A/C# Name A/C Type Office # Internal Use Only: **CONSENT TO TREATMENT** I consent to rehabilitation and related services at: LIVE WELL PHYSICAL THERAPY In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. Initials: TREATMENT OF MINORS I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. Initials: LIABILITY I know and agree that: LIVE WELL PHYSICAL THERAPY is not responsible for loss or damage to personal valuables. Initials: **WAIVER AND RELEASE** I hereby release, discharge and acquit: LIVE WELL PHYSICAL THERAPY its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. Initials: **AUTHORIZATION OF PAYMENT** I hereby assign all benefits directly to: LIVE WELL PHYSICAL THERAPY I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. Initials: FINANCIAL POLICY I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. To assist in establishing your account, please: - Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information. - Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered. - Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf. Initials: NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS I acknowledge receipt of Notice of Privacy Practices. Initials: I acknowledge receipt of the Statement of Patient Rights. Initials: I certify that all of the information provided herein is true and correct. Patient/Guardian Witness Signature Signature _

Medical History Form

Patient Name:	Today's Date:					
Referring Physician:	Date of Birth:		Age:			
Primary Care Physician:	Date of Injury or Onset:					
Date of Next Physician Appointment:						
Reason for Therapy:						
Course of Indiana on Operate Assistant	Ata D. Marile D. Otha	If Other relea	aa avulain.			
Cause of Injury or Onset: Accident Auto Work Other: If Other, please 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 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 Weakness		☐ Multiple Sclerosis			
☐ Asthma	☐ 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 Dysfunction			
☐ Currently Pregnant	☐ Blood Pressure ☐ High ☐ Low		☐ Skin Abnormalities			
☐ Deep Vein Thrombosis (DVT)	☐ HIV or AIDS		☐ Stroke or TIA			
☐ Depression	☐ Hypoglycemia		☐ Thyroid Problems			
☐ Diabetes ☐ Type I ☐ Type II	☐ Hypersensitivity to Hot or Cold		☐ Tuberculosis			
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:						