PHYSICAL THERAPY
CONFIDENTAL HEALTH HISTORY

Name:_____ **Date:**_____ **Gender: Female Male**
Age: _____ **Weight:** _____ **Occupation:**_____ **Last day worked (if applicable):** _____

Is anyone currently coming to your home to give you health care? ◻ Yes ◻ No

Current Symptoms: Describe the problems you are experiencing currently.

_____

_____

How did your symptoms begin? Trauma, gradual, sudden? _____

_____

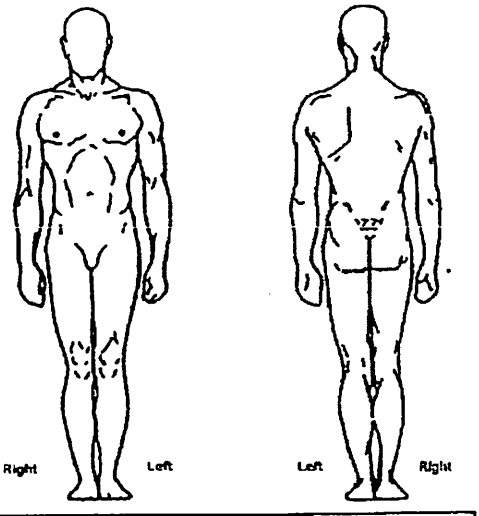
When did you first notice these symptoms? (Use specific day if trauma/accident) _____
Date of most recent flare up: _____
Describe your symptoms: _____

Using the diagram below, mark all area(s) where you are experiencing symptoms.
Use the symbols to describe symptoms:

Are your symptoms?:	Aching	Numbness	Pins and needles	Burning	Stabbing
◻ Getting better					
◻ Staying the same	****	====	OOOO	XXXX	////
◻ Getting worse					

What makes your symptoms WORSE?:
◻ Walking / Standing _____
◻ Sitting / Bending _____
◻ Lying Down (face up / face down / side)
◻ Movement _____
◻ Other _____

What makes your symptoms BETTER?:
◻ Walking / Standing _____
◻ Sitting / Bending _____
◻ Lying Down (face up / face down / side)
◻ Movement _____
◻ Other _____



Frequency of symptoms:
◻ Constant (76-100% of the day)
◻ Frequent (51-75% of the day)
◻ Occasional (26-50% of the day)
◻ Intermittent (0-25% of the day)
◻ Less than Daily _____

Please rate your pain:

0	1	2	3	4	5	6	7	8	9	10
None					Moderate					Need to go to ER/hospital

Have you had any injections or other treatment for these symptoms? No / Yes Dates_____

Which tests have you had for this condition? ◻ X-ray ◻ MRI ◻ EMG ◻ CT ◻ Bone scan ◻ Other
Describe the test results_____

When is your next appointment with the doctor who requested this therapy? _____

Are you CURRENTLY under the care of another health professional in addition to the one prescribing *Physical Therapy?* No / Yes For what condition(s):_____

Have you ever had physical/occupational therapy prior to this occasion? No / Yes

Prior Function and Environment

Please describe your living arrangements *prior* to the onset of this condition:

□ House □ Apartment □ With spouse/family member □ Alone □ Daytime caretaker □ Other _____

Who is responsible for household tasks such as cleaning and preparing meals?

□ Self □ Spouse/family member □ Daytime caretaker □ Other _____

How often did you drive yourself around the community?

□ Always □ Frequently □ Occasionally □ Rarely □ Never

When you are out in the community, do use an assistive device?

□ Wheelchair □ Walker □ Cane □ Crutch(es) □ Other _____

Medical History (Check all conditions you **HAVE** or **HAD** in the past) □ **Check box if NO to all below**

□ AIDS	□ Changes in vision/hearing	□ HIV positive	□ Pneumonia
□ Alcoholism	□ Depression	□ Joint pain	□ Pregnant NOW /RECENT
□ Anemia	□ Diabetes	□ Low blood sugar	□ Psychiatric care
□ Anorexia	□ Dizziness	□ Kidney disease	□ Shortness of breath
□ Appendicitis	□ Emphysema	□ Liver disease	□ Smoker ____# packs/week
□ Arthritis	□ Epilepsy	□ Migraine headaches	□ Weight gain / loss
□ Asthma	□ Fractures / dislocations	□ Multiple Sclerosis	□ Heart attack / disease
□ Bleeding disorders	□ Fibromyalgia	□ Myofascial pain syndrome	□ Heart surgery
□ Bronchitis	□ Hepatitis	□ Neurological disorders	□ Chest pain
□ Bowel or bladder difficulty	□ Hernia	□ Night sweats	□ High blood pressure
□ Bulimia	□ Hemorrhaging	□ Pacemaker	□ Stroke
□ Cancer	□ High cholesterol	□ Persistent night pain	□ Other

Medications (List all medicines you are currently taking) Allergies (Substances/medicines)

Surgeries (List ALL previous procedures. Eg heart, abdominal, bone, ligament, other)

Patient Goals: What do you hope to gain through therapy?

□ Decrease pain □ Increase motion □ Return to specific activity _____

□ Increase strength □ Improve function □ Other _____

Do you use the internet to learn about your health/ your current condition?: No / Yes

What would be your ideal physical therapy treatment:

□ Have regular assistance/guidance with exercises. □ Just show me how to do so I can do on my own

□ To learn about what the problem and the solution. □ I just want help to fix the problem

Please rank the following in regard to your health care needs: (1= most important, 4= least important)

_____Experience _____Outcomes _____Price _____Convenience

Thank you for taking time to complete this evaluation. Our staff hopes to provide you with excellent care to reduce your symptoms and restore you to normal function.

Patient signature _____ **Date** _____

Therapist Signature _____ **Date** _____

Nocona General Physical Therapy

Patient Information Page 1 of 2

*We cannot process your insurance claim without the required fields filled out

Patient's name*:_____ Today's date:_
Street address*: SSN*:
City and State*: _____ Male Female
Zip Code*: _____ Home phone: _____ Date of Birth*: _____ / __ /_
Work phone: _____ Cell: _____ Age:____
Email:_____

Person to contact in case of emergency: _____
Phone: (_____) _____ Relationship:

Have you ever been seen a patient here before? Yes __ No Date seen?_____

Marital Status: _ Married __Widower __ Single **Preferred Language**_____

Ethnicity: _ Hispanic or Latino _ Not Hispanic or Latino

Race: Black/African Am. ____ Amer Indian/Alask Native____ White/Hisp ____Asian/Native Haw___ Other

Advance Directive: Yes___ No___ Smoker: Yes____ Former____ Never_____

PRIMARY INSURANCE COMPANY NAME:_____
Group number: _____ Policy number:_____
Insurance company billing address:_____
Policyholder's name*:_____ Relationship to patient:_____
Policyholder's date of birth*: ____ / ___ /____ Male___ Female __
Policyholder's SSN*: _____
Place of employment:_____
Employer's street address: _____

SECONDARY INSURANCE COMPANY NAME:_____
Policy number: _____ Group number: _____
Insurance company billing address:_____
Policyholder's name*:_____Relationship to patient:_____
Policyholder's date of birth*: ____ / ___ / ____ Male _ Female __
Policyholder's SSN*: _____
Place of employment:_____

IS THIS A WORKER'S COMPENSATION CLAIM? Yes ____ No_____
Date of Injury:_____
Company._____
Address:_____
Phone Number:_____Claim #:_____
*Contact Person:*_____

Nocona General Physical Therapy

Patient Information Page 2 of 2

IS THIS AN ACCIDENT CASE? Yes_ No_ Vehicle: Yes__No___
Insurance Company to Bill: Other: Yes__No___
Name: Adjuster Name:
Address:
Phone #:_____ State:_____ Zip:_____
Claim#:_____

Referring Doctor (the Dr. that sent you to therapy):
Name: _____ Phone:_____ Last Appt:_____
Address:
_____

Primary Physician (your family physician):
Name: _____ Phone: _____ Last Appt:_____
Address_____

I consent to NGH Physical Therapy for treatments/procedures that are necessary or advisable for my care. I hereby grant authorization to Nocona General Hospital Physical Therapy to exchange with and/or release requested information on my medical care to my insurance carrier(s) and to:
_Worker's Compensation _ Patient/Guardian__ Attorney _ Rehabilitation Intermediary

I certify that the information furnished by me is correct and hereby direct and authorize payment of health care benefits due me by insurer to NGH Physical Therapy. I understand that I am financially responsible for payment of fees regardless of insurance coverage. I also certify that I have received the initial patient information from NGH Physical Therapy.
Print Name: _____
Client's Signature: _____ **Date:** _____

I have read and understand Nocona General Hospital's billing and collection policies and initial disclosure. I further understand that I may obtain a copy of this policy upon my request. I do understand that 3 cancels or 3 no-shows to appointments will require me to go back to my doctor and therefore cause me to lose my future appointment times until new script is obtained.

Client's Signature:_____ **Date:** _____

Responsible Party's Signature (if patient is a minor) _____Date:

Witness Print name_____ **Witness Signature**_____ **Date:**

100 Park Rd Nocona, Texas 76255 (940)825-7246 Fax(940)825-3323 Email: noconapt@noconageneral.com

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize *NOCONA GENERAL HOSPITAL* to release to my family members any information about my condition for this stay in the hospital.

_____

(List family members on the above line who may be inquiring about your condition either by phone or in person)

_____ _____

PATIENT NAME **DATE OF BIRTH**

_____ _____

ADMISSION DATE **ACCOUNT NUMBER**

This authorization will expire the day I am discharged from the hospital, or sooner at my request.

_____ _____

Signature of Patient or Authorized Legal Representative **Date**

_____ _____

Relationship to Patient **Witness signature**