PATIENT NAME: FIRST_____**MI**____ **LAST**_____

DATE OF BIRTH _____ **SSN**_____ **MALE** _____ **FEMALE**_____

STREET ADDRESS_____ **APT#**_____

CITY_____**STATE**_____ **ZIP CODE**_____

MAILING ADDRESS IF DIFFERENT_____

HOME PHONE_____**CELL PHONE**_____**EMAIL**_____

EMPLOYER_____**PHONE**_____

ADDRESS _____**CITY**_____ **STATE** ____ **ZIP**_____

SPOUSE'S NAME _____**CELL PHONE**_____**WORK PHONE**_____

EMPLOYER_____**PHONE**_____

ADDRESS _____**CITY**_____ **STATE** ____ **ZIP**_____

EMERGENCY CONTACT_____**RELATIONSHIP**_____**PHONE**_____

REFERRING PHYSICIAN_____ **PHONE**_____

LAST DATE SEEN_____ **NEXT PHYSICIAN VISIT**_____

FAMILY PHYSICIAN_____ **PHONE**_____

ACCIDENT RELATED INJURY? YES___**NO**___ **DATE OF ACCIDENT**_____

HOW DID YOU HEAR ABOUT US? □REFERRING PHYSICIAN □FAMILY □FRIEND □ATHLETIC TRAINER □OTHER_____

PRIMARY INSURANCE: _____PHONE_____
INSURED'S NAME: _____SS#_____DOB _____
EMPLOYER: _____ PHONE_____
RELATIONSHIP TO THE INSURED _____

SECONDARY INSURANCE: _____PHONE_____
****A $10.00 FEE WILL APPLY TO FILE YOUR SECONDARY (DOES NOT APPLY TO MEDICARE)*
INSURED'S NAME: _____ SS#_____ DOB _____
EMPLOYER: _____ PHONE_____
RELATIONSHIP TO THE INSURED_____

CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE **DOSHER PHYSICAL THERAPY ASSOCIATES, LTD.** TO ADMINISTOR TREATMENT AS NECESSARY. I ALSO UNDERSTAND THAT NO GUARANTEE HAS BEEN MADE AS TO THE RESULTS THAT MAY BE OBTAINED.
I AUTHORIZE THE RELEASE OF INFORMATION ACQUIRED IN THE COURSE OF TREATMENT INCLUDING BUT NOT LIMITED TO MEDICAL RECORDS, ORAL COMMUNICATIONS TO MY INSURANCE COMPANY, EMPLOYER, PHYSICIAN(S) AND/OR THIRD PARTY PAYOR.

_____ _____
PATIENT SIGNATURE OR GUARDIAN IF A MINOR **DATE**

PAST HISTORY

Please answer the following questions as applicable and sign the bottom of this form.

Heart Disease
□ Heart Attack
□Arteriosclerosis
□Rheumatic heart disease
□Heart murmur
□CHF
□Pacemaker/Defibrillator

Lungs
□Asthma
□Emphysema
□Turberculosis
□Shortness of Breath

Muscle Conditions
□Carpal Tunnel
□Tennis Elbow
□Back Problems
□Neck Problems

Blood Pressure
□High/Low
□Normal

Other Conditions
□Multiple Sclerosis
□Epilepsy/seizures
□Gout or Lupus
□Sprains/Fractures
□Osteoporosis
□Cancer
□Hepatitis
□Diabetes
□Rheumatoid Arthritis
□Polio
□Night sweats/unexplained fevers
□Fainting
□Hearing loss

□**Other Conditions not listed above**: _____

_____

- **Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following:**

Diabetes □Yes □ No Tuberculosis □Yes □ No Cancer □Yes □ No

- **List any previous injuries/surgeries in the past two years**: _____

_____

- **Have you fallen in the past year which resulted in an injury?**

□Yes: Date of injury: _____
□ No

- **Are you pregnant?** □Yes □No
- **Smoking history**_____
- **Please list any prescription medications you are currently taking (including pills, injections, and/or skin patches)** _____

_____

- **List known allergies:** _____

- **Have you had physical therapy, speech therapy or chiropractic treatment in the current year? If yes, please explain:**

_____

- **Are you currently receiving Home Health services (nursing, therapy, other)?** □Yes □ No

_____ _____

Patient Signature or Guardian if a minor **Date**