ADVANTAGE THERAPY

PATIENT INFORMATION

Name: _____ Today's Date: _____Age: _____

Date of Birth: _____ Sex: Male or Female Marital Status: M W D S

Address: _____City/State: _____Zip Code: _____

Email Address: _____

Mobile Phone Number: _____ Alternate Phone Number: _____

Employer: _____Work Number: _____

Physician: _____

Emergency Contact:

Name: _____ Phone Number: _____Relationship: _____

Insured's Name (if not patient): _____ SSN: _____

Date of Birth: _____ Relationship: _____ Employer: _____

PATIENT MEDICAL HISTORY

Date of Injury or Onset: _____ Date of Surgery: _____

Main Complaint:_____
_____

Type of Injury: ____ Motor Vehicle Accident If yes, what state? _____Date of Accident:_____

____ Recurrence of Previous Injury _____ Athletic/Recreational Injury _____Other

Have you had Home Health services within the past month? ____Y ____N
If yes, date of discharge: _____

Have you attended PT/OT this calendar year? ___Y___N

Do you have a history of any of the following (please circle):
Diabetes Heart Disease Cancer Hypertension

Please briefly explain any answers: _____
_____
_____

(PLEASE CONTINUE TO THE NEXT PAGE)

ADVANTAGE THERAPY

Do you have or have you had any of the following (please circle):

Pace Maker/Defibrillator Asthma Tobacco Use Migraines Sudden Weight Loss Surgeries Dizziness/Fainting Allergies Medication Allergies Recent Fractures Arthritis Ringing in Ears Seizures Nausea/Vomiting Osteoporosis

*Please briefly explain any "Yes" answers:*_____
_____
_____

Please list any medications that you are presently taking: _____
_____

BILLING PREFERENCE

Please circle which billing preference you would prefer: MAIL OR EMAIL

AGREEMENT OF SERVICES

I acknowledge the above information that I have provided is true and correct to the best of my knowledge.

Patient Signature Date

I have read and understand the Establishment Services Agreement as well as the HIPPA Privacy Notice.

Patient Signature Date