



PATIENT INFORMATION			EMAIL ADDRESS: _____		
First Name:	Last Name:	Middle Initial:	Date: / /		
Address:		City:	State:	Zip:	
Birth date: / /	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female	S.S. #: - -		
Home Phone: () -		Alternative Phone (Cell, Pager): () -		Spouse:	
Chose Clinic Because/ Referred to Clinic By <input type="checkbox"/> Dr.:			<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Family	<input type="checkbox"/> Friend
<input type="checkbox"/> Former Patient <input type="checkbox"/> Close to Work/Home <input type="checkbox"/> Website <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Street Sign <input type="checkbox"/> Other:					
WORK INFORMATION					
Employer:			Work Phone () -		Ext.
Occupation:		Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed			
CARE PROVIDER INFORMATION					
Referring Dr:			Referring Dr. Phone: () -		
Regular Dr./PCP			Regular Dr./PCP Phone: () -		
INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)					
Primary Insurance Name:					
Subscriber's Name (If different):				Birth date: / /	
ID. #:		Group/Policy #			
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:					
Name of Secondary Insurance:					
Subscriber's Name:				Birth date: / /	
ID. #:		Group/Policy #			
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:					
AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)					
Insurance Name: <input type="checkbox"/> Auto :			<input type="checkbox"/> Labor & Industries:		
Adjuster/Claim Manager:			Phone:		Ext.:
Address:		City:	State:	Zip:	
Claim #:	Accident Date: / /		Cause:		
ATTORNEY INFORMATION					
Name:		Law Firm:		Phone: () -	
Address		City:	State:	Zip:	
IN CASE OF EMERGENCY					
Name of Local Friend or Relative (Not Living at Same Address):					
Relationship to Patient:		Home Phone: () -		Work Phone: () -	

I authorize my insurance benefits be paid directly to Applied Ortho Physical Therapy. I understand that I am financially responsible for any balance. I also authorize Applied Ortho Physical Therapy to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE

DATE

PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE			JOINT CONDITIONS		
	YES	NO		YES	NO
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
Normal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremity Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE			OTHER CONDITIONS		
	YES	NO		YES	NO
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerotic Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
MUSCLE CONDITION			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
	YES	NO	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Carpal Tunnel R/L	<input type="checkbox"/>	<input type="checkbox"/>	Poor Eyesight	<input type="checkbox"/>	<input type="checkbox"/>
Tennis Elbow R/L	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Back/Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
Limited Limb Movement	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		

LUNGS					
	YES	NO			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>			
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>			
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>			

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Low	<input type="checkbox"/> Smoking	Packs a Day _____
<input type="checkbox"/> 1-2 x Week	<input type="checkbox"/> Standing	<input type="checkbox"/> Medium	<input type="checkbox"/> Alcohol	Drinks a Week _____
<input type="checkbox"/> 3-4 x Week	<input type="checkbox"/> Light Labor	<input type="checkbox"/> High	<input type="checkbox"/> Coffee/Soda	Cups a Week _____
<input type="checkbox"/> 5+ x Week	<input type="checkbox"/> Heavy Labor			
What types of exercise do you perform? : _____				
What things cause stress in your life? : _____				

Are you taking any seizure medication? YES NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?
 YES NO If yes list name: _____

List all medications you are currently taking: _____

List all surgeries in the past two years (Including dates): _____

Are you pregnant? YES NO What week?: _____

Have you had any injuries related to work? YES NO If yes list body part and date.: _____

Have you had any Auto Accidents YES NO If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? YES NO Where: _____

Signature of Patient, Parent, Guardian, Personal Representative _____

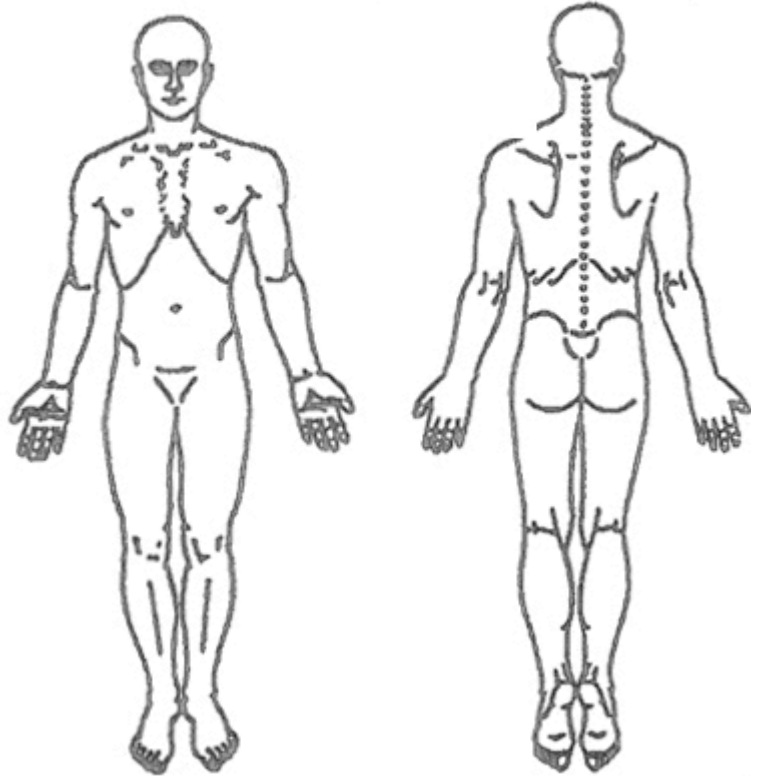
Date _____

Pain and Symptom Status Report

Name: _____

Date: _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing



Ache
MMM
M

Burning
— — —
— —

Numbness
O O O O
O O O

Pins and Needles
□ □ □ □ □ □ □ □ □ □
□ □ □ □ □ □ □ □ □ □

Stabbing
/ / / / / / / /
/ / / /

Other
x x x x
x x x

Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____

Date First Symptom of your problem occurred on: _____

2nd Complaint: _____

3rd Complaint: _____

Please circle on the scale below to indicate your CURRENT level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it gets.**

Please circle on the scale below to indicate your AVERAGE level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it gets.**

Please circle on the scale below to indicate your WORST level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it gets.**

Additional Comments _____

Assignment of Benefits to AppliedOrtho Physical Therapy LLC

Patient Name: _____ DOB _____ ID # _____

Insurance Policy #: _____

Insured Name: _____ Insured Date of Birth _____

Your relationship to the Insured: Parent Spouse Other: _____

Claim # _____

I hereby instruct and direct _____ insurance company to pay by check made out and mailed to:

AppliedOrtho Physical Therapy LLC
704 Lake Varuna Mews
Gaithersburg, MD 20878
240-271-0648

If my/this current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and **mail it to the above address** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

- A photocopy of this Assignment shall be considered as effective and valid as the original.
- I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- I authorize the use of this signature on all insurance submissions.
- I authorize AppliedOrtho Physical Therapy to deposit checks made in my name.
- I authorize AppliedOrtho Physical Therapy to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this _____ day of _____, 20_____.

Signature of Policyholder

Witness

Signature of Claimant, if other than Policyholder