PATIENT INFORMATION FORM

First Name: ______________________ Last Name: ____________________

Mailing Address: ____

City/Town: ______________________ State:_________ Zip:_____________

Sex:__M or F__ [circle one]   Date of Birth: __________ [mm/dd/yyyy]

Email address:____

Home Phone: (_____)______________Cell Phone: (______)_______________

Referring Physician:____

Primary Care Physician:____

Would you mind telling us how you were referred to us? Please circle all that apply.

Internet/ Website   Friend/Family Member   Physician

If you were referred by a friend or family member, may we contact him/her to thank them for the referral? If so please list their name and address:

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MEDICAL INSURANCE INFORMATION

Insurance Company:____

**Subscriber's Name (if not yourself):_________________________________

Subscriber's Date of Birth:______________ Relationship to Patient:_________

Secondary Insurance Name:____

If you have this policy through your spouse, parents or other sources, he/she will be the **subscriber **

Name: ___________________________ **Date:__________________**

Leisure activities, including exercise routines:____

Occupation, including activities that comprise your workday:___________________________________

Age:__________ Height: __________ Weight:__________

Are you on a work restriction from your doctor? Yes No Are you latex sensitive? Yes No

Do you smoke? Yes No Do you have a pacemaker? Yes No

FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No

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Have you RECENTLY noted any of the following (check all that apply)?

- ❑ fatigue
- ❑ fever/chills/sweats
- ❑ nausea/vomiting
- ❑ weight loss/gain
- ❑ difficulty maintaining balance while walking
- ❑ falls
- ❑ numbness or tingling
- ❑ muscle weakness
- ❑ dizziness/lightheadedness
- ❑ heartburn/indigestion
- ❑ difficulty swallowing
- ❑ changes in bowel or bladder function
- ❑ constipation or diarrhea
- ❑ skin changes
- ❑ shortness of breath
- ❑ fainting
- ❑ cough
- ❑ headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ chest pain/angina
- ❑ high blood pressure
- ❑ circulation problems
- ❑ blood clots
- ❑ stroke
- ❑ anemia
- ❑ bone or joint infection
- ❑ chemical dependency (i.e., alcoholism)
- ❑ depression
- ❑ lung problems
- ❑ tuberculosis
- ❑ asthma
- ❑ rheumatoid arthritis
- ❑ other arthritic condition
- ❑ bladder/urinary tract infection
- ❑ kidney problem/infection
- ❑ sexually transmitted disease/HIV
- ❑ pelvic inflammatory disease
- ❑ thyroid problems
- ❑ diabetes
- ❑ osteoporosis
- ❑ multiple sclerosis
- ❑ epilepsy
- ❑ eye problem/infection
- ❑ ulcers
- ❑ liver problems
- ❑ hepatitis
- ❑ pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ high blood pressure
- ❑ diabetes
- ❑ stroke
- ❑ depression
- ❑ tuberculosis
- ❑ thyroid problems
- ❑ blood clots

During the past month have you been feeling down, depressed or hopeless? **YES NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**
Is this something with which you would like help? **YES YES, BUT NOT TODAY NO**

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**

Have you ever taken steroid medications for any medical conditions? **YES NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. __________________________ 2.______________________________ 3.________________________________

4.___________________________ 5.______________________________ 6.________________________________

What date (roughly) did your present symptoms start?____

What do you think caused your symptoms? ____

My symptoms are currently: ❑ **Getting Better** ❑ **Getting Worse** ❑ **Staying about the same**

I should not do physical activities that might make my pain worse: ❑ **Disagree** ❑ **Unsure** ❑ **Agree**

Treatment received so far for this problem (chiropractic, injections, etc) ______________________________

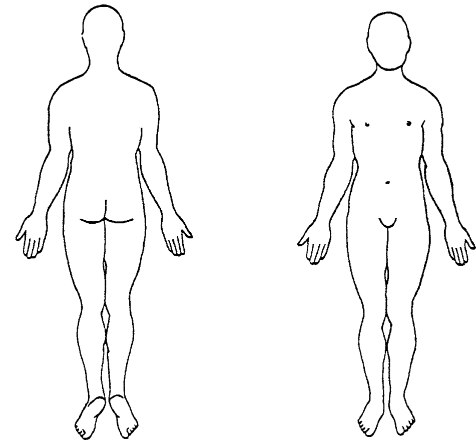
Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____________________________

Have you ever had this problem before: ❑ **Yes** ❑ **No** **When**__________ **Treatment rec'd**______________

How long did it take for you to feel better? ____

Body Chart:

Please mark the areas where you
feel symptoms on the chart to the right with
the following symbols to describe your symptoms:



↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**

My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

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Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:
1. ____
2. ____
3. ____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:
1. ____
2. ____
3. ____

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise
When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

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Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

Your current level of pain while completing this survey:___________

The best your pain has been during the past 24 hours: ___________

The worst your pain has been during the past 24 hours: ___________

CURRENT MEDICATION LIST

Date:_______________

PATIENT INFORMATION

First Name		Last Name		Date of Birth	

KNOWN MEDICATION ALLERGIES

PLEASE LIST ALL MEDICATIONS/SUPPLEMENTS/VITAMINS INCLUDING DOSE

Medication/Supplement/Vitamins Name	Dose / How Often	Oral, Injection, Topical etc…

36 Industrial Way ◇ Suite 1 ◇ Rochester, NH 03867 ◇ voice 603-335-4700 ◇ fax 603-335-4704

I hereby agree to be evaluated by Willem Verweij Physical Therapy, LLC and agree to such treatment that in the opinion of the physician(s) and therapist(s) is necessary.

I understand that it is my responsibility to obtain any insurance referrals prior to my first Physical Therapy appointment. If I schedule and attend my appointments without proper insurance referrals, I understand that I will be accepting financial responsibility for each visit without a referral.

I understand that it is my responsibility to verify Physical Therapy coverage with my insurance carrier(s) and that I am financially responsible for charges not covered by my insurance carrier.

I understand that it is the policy of Willem Verweij Physical Therapy, LLC to ask for backup insurance for all workers' compensation patients in the event the workers' comp claim is denied. I also understand that it is my responsibility to obtain any health insurance referrals for this backup insurance prior to my first appointment. If no referral is available, and my workers' comp claim is denied, I will be held liable for all charges.

Assignment of Insurance Benefit (Medicare included) and Release of Information

- I authorize and request payment of medical benefits directly to Willem Verweij Physical Therapy, LLC.
- I authorize the release of any medical information necessary to process my Insurance claim(s).
- I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.
- I agree that a photocopy of this form may be used in lieu of the original.

Signature: ____ Date: ___________

Statement of Financial Responsibility

I accept financial responsibility for any and all charges incurred at Willem Verweij Physical Therapy, LLC including (but not limited to) any balances which may not be covered by my insurance, such as my deductible, coinsurance, co-payments and the balance of the usual and customary fee. This balance is payable at the time of service or upon receipt of statement.

Signature: ____ Date: ___________

Acknowledgement of Receipt of Notice

I have received the Notice of Privacy Practices provided by Willem Verweij Physical Therapy, LLC. I understand that the terms of this notice may change and I may receive a copy of a revised notice by contacting Willem Verweij Physical Therapy, LLC located at 36 Industrial Way, Suite 1, Rochester, NH 03867.

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Patient Name

____

Patient Signature Date

I authorize ____

(spouse, parent etc .... please print their full name)

To receive my medical and billing information from
Willem Verweij Physical Therapy, LLC.

____

Patient Signature Date