Core Physical Therapy and Performance, LLC

(Please Print Clearly)

Patient's First Name: _____ Last Name: _____ Middle: _____

Mailing Address: _____ City: _____ St: _____ Zip: _____

Street Address: _____ City: _____ St: _____ Zip: _____

DOB: ___ / ___ / ___ Patient's SS#: ___ / ___ / ___ DL #: _____ Gender: ☐ Male ☐ Female

Hm. Ph#: (___) _____ Cell #: (___) _____ Email: _____

Patient's Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other Student: ☐ Full-time ☐ Part-time

Employment Status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Self-Employed ☐ Retired ☐ Disabled

Place of Employment: _____ Occupation: _____

Wk.#: (___)_____ Address: _____ City:_____ St:____ Zip:_____

Spouse's Name: _____ Spouse's DOB: ___ / ___ / ___ Spouse's SS#: ___ / ___ / ___

Spouse's Place of Employment: _____ WK#: (___) _____

Responsible Party/Guardian: (If not the patient; or if patient is a minor (under the age of 18):

First Name: _____ Last Name: _____ Middle: _____

Mailing Address: _____ City: _____ St: _____ Zip: _____

Street Address: _____ City: _____ St: _____ Zip: _____

DOB: ___ / ___ / ___ SS#: ___ / ___ / ___ DL #: _____ Hm. Ph#: (___) _____

Cell #: (___) _____

Place of Employment_____ Wk.#: (___)_____

Address: _____ City: _____ St: ____ Zip: _____

Emergency Contact: _____#(___)_____ Relationship: _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:
I authorize the release of any and all medical information necessary to process my claim for services provided by Core Physical Therapy and Performance, and request payment of benefits to Core Physical Therapy and Performance, LLC.

I hereby consent to the release and disclosure of my personal health information to Core Physical Therapy and Performance, LLC. This release authorization includes my personal health information consisting of MRI results, test results, etc. for the purpose of deciding plan of treatment.

Patient's/Responsible Party's Signature: _____ Date: _____

Core Physical Therapy and Performance, LLC

Medical History Form

Patient's Name: _____ DOB: ___ / ___ / ___ Date completed: _____

What caused you to seek physical therapy/medical attention? _____

Referring Physician: _____ Return Date to Physician: _____

Your condition is related to: ☐ Employment ☐ Auto Accident ☐ Home ☐ Other

Please give a brief explanation: _____

Date of Condition / Accident: ____ / ____ / ____ State Accident Occurred: _____

What is your major complaint? Please be as detailed as possible. _____

_____

_____

Have you ever had this problem before? ☐ Yes ☐ No Please Explain: _____

What makes your pain better? _____

What makes your pain worse? _____

Is this problem getting better or worse? _____

What type of treatment have you received for this condition? ☐ X-rays ☐ medications ☐ injection ☐ bone scan

☐ CT/CAT Scan ☐ MRI ☐ physical therapy ☐ chiropractic ☐ surgery ☐ home health

Please describe (agency, etc.) _____

_____

Please check problems diagnosed by a doctor. Circle if you are currently being treated.

___ Bronchitis / Emphysema / Lung Disease
___ Pneumonia
___ Abnormal Chest X-ray
___ Chronic Fatigue Syndrome
___ Dizziness / Fainting Spells
___ Lupus
___ Thrombosis / Phlebitis
___ Sciatica
___ Fibromyalgia
___ Bursitis
___ TMJ Dysfunction
___ Carpal Tunnel Syndrome
___ Epilepsy
___ Muscular Dystrophy
___ Gout
___ Implants
___ High / Low Blood Pressure
___ Heart Disease
___ Tuberculosis
___ Pregnant – Due Date: _____

___ Blood-Borne Pathologies – ☐ HIV ☐ AIDS ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C

___ Tumors / Cancer - Year _____ Type _____ Remission: ☐ Yes ☐ No

___ Infection / Inflammation – What? Where? _____

___ Sprains / Dislocations – Where: _____

___ Broken Bones – Please list: _____

___ Pace Maker - If yes, date received: _____

Please list any medications you are currently taking and what they are for: _____

_____

Please list any previous surgeries: _____

_____

Core Physical Therapy and Performance, LLC
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Shreveport, LA 71106
(318) 868-6172

HIPAA-ACKNOWLEDGEMENT OF RECEIPT
Notice of Privacy Practices

Printed Patient Name: _____

Patient Birth Date: _____

We at Core Physical Therapy are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. If you would like a copy of the Notice, please ask.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

_____ _____
Signature of patient or patient's representative/parent Date

_____
Printed name of patient or patient's representative/parent

_____
Relationship to patient