SPEARFISH
PHYSICAL THERAPY

Patient & Insurance Information Date: _____

Patient Information

Name: _____ Date of Birth:_____
Address: _____
Phone: _____ Cell Phone: _____ Work: _____
Email: _____
Gender: _____ Marital Status: S M W D
Employer: _____ Occupation: _____
Employer Address: _____
Spouse Name: _____ Phone:_____
If under the age of 18, Parent/Guardian Name: _____ Phone: _____
Referring Physician: _____ Primary Care Physician: _____
How were you referred to us? (Circle One): Physician Friend Online Facebook Newspaper Other_____

Emergency Contact Name: _____ Phone: _____

Insurance Information

Primary Insurance Name: _____ ID#: _____
Address: _____
Policy Holder Name: _____ Date of Birth: _____

Secondary Insurance Name: _____ ID#: _____
Address: _____
Policy Holder Name: _____ Date of Birth: _____

Worker's Compensation Insurance Name: _____
Address: _____
Case Manager/Contact Person: _____ Phone: _____
Claim #: _____ Date of Injury: _____
Employer: _____

Please initial each term of agreement:

_____ I authorize Spearfish Physical Therapy to submit claims on my behalf and for my insurance benefits to be paid directly to Spearfish Physical Therapy LLC.

_____ I understand that charges not covered by my insurance company such as applicable copayments, coinsurance, deductibles and non-covered items will be my responsibility.

_____ I understand that there is a 1% interest fee charged to all account balances over 60 days. In the event that this account is referred to a collection agency, the undersigned agrees to pay all reasonable costs of collection or attorney fees if applicable.

_____ I have read and reviewed HIPPA policies and I understand that Spearfish Physical Therapy may disclose protected health information for the purposes of payment, treatment and healthcare operations.

_____ I have read, understand, and agree to the above Spearfish Physical Therapy policies.

_____ _____
Signature of Patient or Responsible Party Date

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Patient Health History Information Date: _____

Height: _____ Weight: _____

Chief Complaint: _____
Date of Onset: _____ Possible Cause: _____

What makes symptoms worse: _____
What makes symptoms better: _____

Have you had previous physical therapy treatments for this condition? Yes or No

Have you had any imaging (x-rays, CT scan, MRI etc)? Yes or No Where: _____

Current Medications (we can make copy of list):_____
_____

Surgeries (Past or Present): _____
_____

Medical History (Past or Present): check all that apply

- ☐ High Blood Pressure
- ☐ Diabetes Type 1 or 2
- ☐ Hypoglycemia
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Stroke
- ☐ Liver or Kidney Disease
- ☐ Multiple Sclerosis
- ☐ Rheumatoid Arthritis
- ☐ Recent Infection
- ☐ Cancer (Location:_____)
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Asthma
- ☐ Allergies
- ☐ Vertigo/Dizziness
- ☐ Depression
- ☐ Mental Disorder
- ☐ Chemical Dependency

Other:_____
_____

Do you have a pacemaker? YES or NO
Are you Pregnant? YES or NO
Do you smoke? YES or NO
Do you exercise when injury free? YES or NO

What are your goals for physical therapy and what activities would you like to get back to?
_____

I attest that this medical history is accurate and complete to the best of my knowledge. I consent to receive physical therapy services that are deemed medically necessary and appropriate by my physical therapist.

_____ _____
Signature of Patient or Responsible Party Date