



EMPIRE PHYSICAL THERAPY & Athletic Rehabilitation, PC

Confidential Medical History

Name _____ Birth Date: _____ S.S #: _____

Mailing Address: _____ Gender: Male / Female

Marital Status: M/S Home Number: _____ Cell Number: _____

Employer: _____ Work Number: _____

Referring MD: _____ Body Part: _____

Insurance: I.D #: _____

Secondary Insurance: _____

Date of Injury: _____ **Work related injury? YES / NO** **Auto accident? YES / NO**

Any Diagnostic or Rehabilitative services for this injury? MRI / X-ray's / Other: _____

List any additional surgeries: _____

List all medications you are currently taking: _____

Any allergies? YES / NO If so, please list: _____

Do you have any of the following:

	Yes	No
Asthma, Bronchitis, Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath / Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack / Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Stroke / TIA	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clot / Emboli	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Trouble / Goiter	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Cancer or Chemo / Radiation	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis / Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
Bowel or Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
Severe / Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Vision / Hearing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or Faintness	<input type="checkbox"/>	<input type="checkbox"/>

Pain when performing the following:

	Mild	Moderate	Severe
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changing positions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extended Computer Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting (prolonged)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing (prolonged)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	Daily _____	Weekly _____	
Are you pregnant?	_____		



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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Empire Physical Therapy and Athletic Rehabilitation, regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

I acknowledge that I have seen the "Notice of Privacy Practices". I understand that I may ask questions about the "Notice of Privacy Practice" at any time.

Patient: _____
Print Name

Signature

Parent / Guardian: _____

Date: _____