McVay Physical Therapy

"Smooth sailing toward less pain"

147 County Rd. Suite 301A
Barrington, RI 02806
Phone: 401-643-1776
Fax: 401-694-0965

www.mcvayphysicaltherapy.com

PLEASE FILL OUT ALL FOUR PAGES!

Date:_____ Date of injury (or surgery): _____

Last Name:_____First_____MI____

Phone:_____ Cell Phone:_____

Address:_____City:_____

State:_____Zip:_____ E-mail address: _____

Age:_____Date of Birth:_____Social Security:_____

Name of Primary Care Physician:_____

Referring Physician:_____

Type of Primary Insurance:_____

Insured Card Holder's Name (if different): _____

Date of Birth (if different):_____

Injury Related to Auto Accident? YES ____ NO ____

Injury Related to Employment? YES ____ NO ____ Is this a Liability Injury? YES ____ NO ___

If Liability, Attorney Name: _____ Phone#: _____

Emergency Contact Name: _____ Phone#: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS: My physician/ physical therapist is authorized to provide to my referring physician, insurance company or their representatives, or my attorney information they may require regarding my condition while under their treatment or observation, including but not limited to history obtained, medical history, physical findings, diagnosis, prognosis and treatment recommended.

FINANCIAL AGREEMENT: In consideration of the services rendered by my physical therapist at my request and direction, I understand I am responsible for, and agree to pay in full all charges incurred for services rendered. I further understand that in the event that special arrangement

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have been made to have payment made through my insurance company, and the carrier elects not to cover any or all of the claim, I am responsible for the balance in full. I further agree to pay lawful and reasonable interest charges after thirty (30) days from date of billing on any unpaid balance. I understand that I am responsible for contacting my insurance to understand my benefit coverage for physical therapy, including co-pay or co-insurance.

HIPAA: I have received and read a copy of the McVay Physical Therapy HIPAA privacy notification (available in the waiting area or at www.mcvayphysicaltherapy.com)

Photo release: Photographs may be taken of me in relation to my condition (permission will be asked before you are photographed). I agree to use of these for promotional use only.
Check if you elect NOT to have photos used for promotion: ☐

SIGNATURE OF PATIENT DATE

History of problem:

Dominant hand: _____

What brings you here today and how did your problem start? _____
_____
_____
_____

Please state the reason you are here and any goals you wish to accomplish in therapy:
_____
_____
_____

Please state any other treatment you have tried or are trying: _____
_____

What is your occupation/job duties?: _____

What are your recreational activities/sports/hobbies? _____
_____

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Please list all medications you are currently taking: _____

_____

_____

_____

Please list all ALLERGIES (Latex, medication…): _____

_____

Please list any instructions from your doctor related to the condition you are here for:

_____

_____

On a scale of 0-10, please rate your CURRENT pain level:
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (need to go to the hospital)

What is your pain at its LEAST level over the last two weeks?
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (need to go to the hospital)

What is your pain at its WORST level over the last two weeks?
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (need to go to the hospital)

Have you ever had or been diagnosed with any of the following (OVER):

Broken bones/fractures	Yes	No	Comments: _____
Dislocations	Yes	No	Comments: _____
Heart disease	Yes	No	Comments: _____
Asthma/lung disease	Yes	No	Comments: _____
Neck pain	Yes	No	Comments: _____
Back pain	Yes	No	Comments: _____
Diabetes	Yes	No	Comments: _____
High blood pressure	Yes	No	Comments: _____
Cancer	Yes	No	Comments: _____
Circulation problems	Yes	No	Comments: _____
Numbness/tingling	Yes	No	Comments: _____
Dizziness/ Lightheadedness	Yes	No	Comments: _____

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Recent weight loss/gain	Yes	No	Comments: _____
Surgeries (please list/date)	Yes	No	Comments: _____

_____

Depression	Yes	No	Comments: _____
Balance problems/Weakness	Yes	No	Comments: _____
Pain/blood with bowel movement/urination	Yes	No	Comments: _____
Pain with coughing/sneezing	Yes	No	Comments: _____
Open wounds	Yes	No	Comments: _____
Skin rashes/conditions	Yes	No	Comments: _____
Swelling/edema	Yes	No	Comments: _____
Metal implants	Yes	No	Comments: _____
Thyroid problem/disease	Yes	No	Comments: _____
Fever	Yes	No	Comments: _____
Chills	Yes	No	Comments: _____
Chest/Abdominal Pain	Yes	No	Comments: _____
Joint Pain	Yes	No	Comments: _____
Recent Vomiting/Diarrhea	Yes	No	Comments: _____

Any other medical problem that we should be aware of?: _____

There is a $25 cancellation fee if less than 24 hour notice is given.