**PLEASE FILL OUT ALL FOUR PAGES!**

**Date:**Click here to enter text. **Date of injury (or surgery):**Click here to enter text.

**Last Name:**Click here to enter text. **First Name:** Click here to enter text.**MI:**

**Phone:**Click here to enter text. **Cell Phone:**Click here to enter text. **Confirm appointments by Text** **[ ] Call** **[ ]**

**Street Address:**Click here to enter text. **City:**

**State:**Click here to enter text. **Zip:**Click here to enter text. **E-Mail Address:**Click here to enter text.

**Age:** Click here to enter text.**Date of Birth:** Click here to enter text.**Gender:**Click here to enter text.

**Primary Care Physician:**Click here to enter text. **Referring Physician:**Click here to enter text.

**Primary Insurance (Name only):**Click here to enter text.

**\*If Medicare is your primary insurance please let us know if you recently have had home health care\***

**Secondary/Supplemental Insurance (Name only):**Click here to enter text.

**\*Please note we do not accept Rhode Island MEDICAID or Neighborhood Health Plans\***

**Injury Related to an Auto Accident: YES** **[ ]  NO** **[ ] Workers’ Comp Injury: YES****[ ]  NO****[ ]**

**If Workers’ Comp, provide Claim Number and Billing Agency:**

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**Liability Injury: YES****[ ]  NO** **[ ] (Please note, we do NOT bill attorneys directly)**

**If Liability, Attorney Name:**Click here to enter text. **Phone #** Click here to enter text.

**Emergency Contact Name:**Click here to enter text. **Phone #** Click here to enter text.

**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 of 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 arrangements have been made to have payment made through my insurance company, and the carrier elects not 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 deductibles, co-pay or co-insurance. If any claims are denied, I am responsible for the charges rendered.
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).**

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**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 photographs for promotional use only.

Check if you elect NOT to have photos used for promotion [ ]

***There is a $75 cancellation fee if less than 24 hour notice of cancellation is given***

**SIGNATURE OF PATIENT: By typing my name here I electronically sign and agree to the above:**

**Name:** Click here to enter text. **Date:**Click here to enter text.

**Medical history:**

Dominant Hand: Choose an item.

What brings you here today and how did your problem start? Click here to enter text.

Please state the reason you are here and any goals you wish to accomplish in therapy: Click here to enter text.

Please state any treatment you have tried or are trying: Click here to enter text.

What are your occupation and job duties? Click here to enter text.

What are your recreational activities, sports, & hobbies? Click here to enter text.

Please list all medications you are currently taking: Click here to enter text.

Please list all ALLERGIES (Latex, medication..): Click here to enter text.

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 [ ]  (Hospital visit needed)

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[ ]  (Hospital visit needed)

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[ ]  (Hospital visit needed)

What is your **STRESS** Level?
 (No pain) 0 [ ]  1 [ ]  2 [ ]  3[ ]  4 [ ]  5 [ ]  6 [ ]  7 [ ]  8 [ ]  9 [ ]  10[ ]  (Hospital visit needed)

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**Have you ever had or been diagnosed with any of the following:**

Broken bones/fractures Yes [ ]  No [ ]  Comments: Click here to enter text.

Dislocations Yes [ ]  No [ ]  Comments: Click here to enter text.

Heart disease Yes [ ]  No [ ]  Comments: Click here to enter text.

Asthma/lung disease Yes [ ]  No [ ]  Comments: Click here to enter text.

Neck pain Yes [ ]  No [ ]  Comments: Click here to enter text.

Back pain Yes [ ]  No [ ]  Comments: Click here to enter text.

Diabetes Yes [ ]  No [ ]  Comments: Click here to enter text.

High blood pressure Yes [ ]  No [ ]  Comments: Click here to enter text.

Cancer Yes [ ]  No [ ]  Comments: Click here to enter text.

Circulation problems Yes [ ]  No [ ]  Comments: Click here to enter text.

Numbness/tingling Yes [ ]  No [ ]  Comments: Click here to enter text.

Recent weight loss/gain Yes [ ]  No [ ]  Comments: Click here to enter text.

Surgeries (please list/date) Yes [ ]  No [ ]  Comments: Click here to enter text.

Depression Yes [ ]  No [ ]  Comments: Click here to enter text.

Balance problems/Weakness Yes [ ]  No [ ]  Comments: Click here to enter text.

Pain/blood with bowel Yes [ ] No [ ]  Comments: Click here to enter text.

Movement/urination Yes [ ]  No [ ]  Comments: Click here to enter text.

Pain with coughing/sneezing Yes [ ]  No [ ]  Comments: Click here to enter text.

Open wounds Yes [ ]  No [ ]  Comments: Click here to enter text.

Skin rashes/conditions Yes [ ]  No [ ]  Comments: Click here to enter text.

Swelling/edema Yes [ ]  No [ ]  Comments: Click here to enter text.

Metal implants Yes [ ]  No [ ]  Comments: Click here to enter text.

Thyroid problem/disease Yes [ ]  No [ ]  Comments: Click here to enter text.

 Recent fever Yes [ ]  No [ ]  Comments: Click here to enter text.

 Recent chills Yes [ ]  No [ ]  Comments: Click here to enter text.

 Chest/Abdominal Pain Yes [ ]  No [ ]  Comments: Click here to enter text.

 Joint Pain Yes [ ]  No [ ]  Comments: Click here to enter text.

 Recent Vomiting/Diarrhea Yes [ ]  No [ ]  Comments: Click here to enter text.

Describe your current mattress and pillow: Click here to enter text.

Any other medical problems that we should be aware of? Click here to enter text.

Dizziness/ Lightheadedness Yes [ ]  No [ ]  Comments: Click here to enter text.

If you have dizziness:

On a scale of 0-10, please rate your CURRENT level of dizziness:
 (None) 0 [ ]  1 [ ]  2 [ ]  3[ ]  4 [ ]  5 [ ]  6 [ ]  7 [ ]  8 [ ]  9 [ ]  10[ ]  (Hospital visit needed)

What is your dizziness at its LEAST level been over the last two weeks?
 (None) 0 [ ]  1 [ ]  2 [ ]  3[ ]  4 [ ]  5 [ ]  6 [ ]  7 [ ]  8 [ ]  9 [ ]  10[ ]  (Hospital visit needed)

What is your dizziness at its WORST level been over the last two weeks?
 (None) 0 [ ]  1 [ ]  2 [ ]  3[ ]  4 [ ]  5 [ ]  6 [ ]  7 [ ]  8 [ ]  9 [ ]  10[ ]  (Hospital visit needed)