Westside Wellness & Rehabilitation

Physical Therapy ▪ Sports Medicine ▪ Wellness

Patient Information:

Name: ____

Address: ____

City: ____________________ **State:** __________ **Zip code:** ______

Home phone: ______________ **Work phone:** __________________

DOB: ______________ **E-mail:** ______________ **Sex:** _______

Employer: ________________ **Occupation:** __________________

Spouse or Parent/Guardian:

Name: ___________________ **Relationship to patient:** ___________

Address: ____

City: ____________________ **State:** __________ **Zip code:** ______

Employer: ________________ **Work phone:** __________________

Emergency Contact:

Name: ___________________ **Phone:** ______________________

Injury Information:

Date of injury: ______________ **Date of Surgery:** ______________

MEDICAL HISTORY FORM

NAME:________________________ OCCUPATION:___________________ AGE:_____

DATE OF ONSET: Injury/Problem/Surgery: ___________________________________

Briefly state previous treatment, if any: ____

____

Do you have now, or have you ever had, any of the following:

DIABETES	YES___NO___	ALLERGY TO COLD	YES__ NO___
HIGH BLOOD PRESSURE	YES__ NO___	OTHER ALLERGIES	YES__ NO___
PACEMAKER	YES__ NO___	PREVIOUS SURGERY	YES__ NO___
CHRONIC HEADACHES	YES__ NO___	SIEZURES	YES__ NO___
KIDNEY PROBLEMS	YES__ NO___	METAL IMPLANTS	YES__ NO___
NERVOUS DISORDERS	YES__ NO___	DIZZINESS	YES__ NO___
HERNIA	YES__ NO___	CANCER	YES__ NO___
ALLERGY TO HEAT	YES__ NO___	PREGNANT	YES__ NO___
BONE DISEASE	YES__ NO___	OSTEOPOROSIS	YES__ NO___
FRACTURES	YES__ NO___	BOWEL PROBLEMS	YES__ NO___
BLADDER PROBLEMS	YES__ NO___	RECENT WEIGHT LOSS	YES__ NO___
PINS & NEEDLES	YES__ NO___	CIRCULATORY DISEASE	YES__ NO___
PROBLEMS WITH BOTH ARMS OR LEGS AT THE SAME TIME			YES__ NO___

If YES to any of the above, please explain and give appropriate details: ______________________

____

____

Are you presently taking any medications? YES___NO___

If YES, please list your medications and for what condition: ______________________________

____

____

Have you had any X-rays, CAT scans, MRI's, or other diagnostic tests for your recent disorder?
YES__ NO___ If YES, please explain the findings as you understand them. _________________

____

____

Is there anything else you think I should know about your general health, or current condition?
Please explain and, if necessary, we can talk about it: ___________________________________

____

____

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Assignment of Benefits:

Patient name: ________________________**DOB:**______________________

Patient Identification and/or group number: ________________________

Primary Insurance Company: ____________________________________

Billing address: ____

Phone: ____

Secondary Insurance Company: __________________________________

Billing address: ____

Phone: ____

I hereby authorize Westside Wellness and Rehabilitation to provide to my insurance carrier(s) any and all requested information regarding my health care. I also authorize my insurance carrier(s) to pay Westside Wellness and Rehabilitation and/or Amy B Fee MPT directly for services rendered.

Signature: _________________________ **Date:** _______________________
(Patient and/or Parent/Guardian)

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Cancellation Policy:

I understand that a cancellation must be made within 24 hours in advance of my scheduled appointment or I will be charged $75.00 cancellation fee.

* Your Insurance Does Not Cover This*

Signature: ____________________ Date: _______________
(Patient or Parent/Legal Guardian)

Consent to Treat:

I hereby consent to treatment by Westside Wellness and Rehabilitation.

Signature: ____________________ Date: _______________
(Patient or Parent/Legal Guardian)