



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__ | SEIZURES | 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)