



Welcome to PTC Physical Therapy We are dedicated to quality service. To help us better serve you, please take a moment to fill out the following information:

Client Information :

First _____ MI ____ Last _____ Sex _____

Birth Date: ____/____/____ Age: _____

Address _____ City _____ St ____ Zip _____

Home () _____ Cell () _____ Email address _____

Emergency Contact Name _____ Phone # _____

Parent/ Guardian Name (if under age 18) _____

Check this box to receive our monthly fitness, wellness, and nutrition newsletter (e-mailed)

Primary Insurance :

Company _____ Subscriber ID _____ Group # _____

Subscriber Name: First _____ MI ____ Last _____ DOB _____

Relationship to client is **Self** ____ **Spouse** ____ **Parent** ____ **Other** ____

Secondary Insurance : (if applicable)

Company _____ Subscriber ID _____ Group # _____

Subscriber Name: First _____ MI ____ Last _____ DOB _____

Relationship to client is **Self** ____ **Spouse** ____ **Parent** ____ **Other** ____

Thank you for choosing PTC Physical Therapy for your therapy needs. We will bill your insurance company for you. Once we receive payment from your insurance provider, any patient responsible portions will be billed to you. **Copays are due at time of service.** Note you may be subject to annual deductibles. It is in your best interest to contact your insurance company to verify your therapy benefits and your copay prior to your first visit. Pls. indicate your current physical therapy copay here _____ and we will verify with your provider.

I authorize my insurance benefits to be paid directly to PTC Physical Therapy,LLC. I understand I am responsible for any balance due, attorney or collection costs for services rendered not covered by my insurance due to lack of prior authorization or written referral. I authorize the release of medical information required for my claims to be processed. This may include information regarding diagnosis or treatment of HIV, STD's, drug or alcohol use or abuse, mental illness, or psychiatric treatment. Interest or penalties maybe charged. I authorize PTC Physical Therapy to contact the Insurance Commissioner to aid in receiving payment if necessary.

Signature _____ Date _____

(Parent or guardian if under 18)



Patient Health History :

Date of your next scheduled MD Appointment: _____
What is your primary injury or health concern? _____

Briefly describe the history of your present ACCIDENT, INJURY, ILLNESS, or CONDITION:

Onset of injury or Surgery Date: _____ Injured at work? _____ In an auto accident? _____

What is your occupation? _____ Name of Company _____

Description- include how you were injured:

Please list any special concerns, questions, or expectations you may have regarding physical therapy:

Please describe the type of pain: Burning, aching _____

Pain level: (1-10) _____ / Location: _____

What activities / movements/ positions make your symptoms better? _____

What activities/ movements/ positions make your symptoms worse? _____

Have you fallen in the past Year? _____ If so, how many times? _____ Did you sustain an injury? Y / N
Explain: _____

Have you had any Physical Therapy during the current year? Y / N

Have you had other treatments for the same condition for which you are here today? Y / N

Please circle all that apply:

PT Chiropractic Massage Cortisone Injections Other: _____

List ALL medications you are currently taking:

List all recent diagnostic studies (CAT scan, MRI, X-Ray, etc.) & where taken:

Do you have any METAL anywhere in your body (other than teeth), such as pins/plates, pacemaker, stints, etc.?
Describe: _____

List ALL surgeries you have had; give procedures and dates if possible: _____

(Use other side as needed)



Have you had or currently have any of the following? If yes, please give dates and if they currently persist.

High Blood Pressure-----Y/N	Arthritis/Osteoarthritis---Y/N	Dizzy Spells----- Y/N
Heart Condition----- Y/N	Cancer-----Y/N	Diabetes----- Y/N
Circulation Disorders---- Y/N	High Cholesterol----- Y/N	Osteoporosis-----Y/N
Seizures-----Y/N	Lung Disorders-----Y/N	Tobacco use-----Y/N

Allergic to tapes/lotions? Y/N Explain: _____
 Are you Pregnant? -----Y/N

Your goals for Physical Therapy /Any Final Concerns or Questions?:

Notice of Privacy Practices :

We keep a record of the health care service we provide to you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes us to do so. You may see your record or get more information about it by contacting PTC Physical Therapy.
 Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By signing below I acknowledge receipt/review of the Notice of Privacy Practices.
 Our privacy policy link: www.physicaltherapycoach.com/privacy-policy

Patient or legally authorized signature _____

Printed Name _____ Date _____

Return by Fax to: (888)-802-0652 or Mail to:
 PTC Physical Therapy
 PO Box 7242
 Cumberland RI 02864