

PRESSLER
PHYSICAL THERAPY CLINIC
 402 West Wheatland Road, Suite 100
 Duncanville, TX 75116

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TODAY'S DATE ___/___/___

NAME _____ D.O.B. ___/___/___ AGE _____
LAST FIRST M.I.

CELL PH _____

ADDRESS _____ HOME PH _____
STREET APT # CITY/STATE ZIP CODE INCLUDE AREA CODE

SS # ___ - ___ - ___ DL # _____ MARITAL STATUS (check one) ___M ___S ___W ___D ___OTHER

EMPLOYER _____ ADDRESS _____
STREET CITY/STATE ZIP CODE

EMPLOYER PHONE _____ OCCUPATION _____
INCLUDE AREA CODE

SPOUSE _____ D.O.B. ___/___/___ SS# ___ - ___ - ___

EMPLOYER _____ EMPLOYER PHONE _____
INCLUDE AREA CODE

NAME OF FRIEND OR RELATIVE _____ PHONE _____
 NOT LIVING WITH YOU INCLUDE AREA CODE

MEDICAL INFORMATION

HAVE YOU HAD ANY PHYSICAL THERAPY THIS YEAR? ___ Y ___ N FOR PRESENT ILLNESS/INJURY ___ Y ___ N

IF SO, WHERE AND FOR HOW LONG? _____ \$ _____

IS YOUR VISIT TODAY RELATED TO AN AUTO ACCIDENT? ___ NO ___ YES ACCIDENT DATE: _____

HAVE YOU HAD OR CURRENTLY DO YOU HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS?

- | | |
|---------------------------|--------------------------------------|
| _____ DIABETES | _____ THYROID PROBLEMS |
| _____ CANCER | _____ TB |
| _____ HIGH BLOOD PRESSURE | _____ MENTAL PROBLEMS |
| _____ HEART TROUBLE | _____ ARTHRITIS |
| _____ EPILEPSY/SEIZURES | _____ OTHER (DESCRIBE BELOW) |
| _____ HEPATITIS | _____ ANY ALLERGIES (DESCRIBE BELOW) |
| _____ STROKE | _____ NONE OF THE ABOVE |

DESCRIPTION OF PAST MEDICAL PROBLEMS/ SURGERY _____

ANY RECENT SURGERY OR ACCIDENTS INCLUDING ANY RELATED TO YOUR VISIT TODAY

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TODAYS DATE ____/____/____

PATIENT NAME _____

INSURANCE INFORMATION

INSURANCE CO. _____ IS THIS AN: ____ HMO ____ PPO ____ INDIVIDUAL POLICY

PRIMARY INSURED PERSON _____ SS # ____ - ____ - _____

EMPLOYER _____ PRIMARY INSURED'S D.O.B. ____/____/____

POLICY / GROUP # _____ ID/SUBSCRIBER # _____

MEDICARE INFORMATION

IS MEDICARE PRIMARY? ____ YES ____ NO MEDICARE # _____

SECONDARY POLICY COMPANY _____ **PHONE** _____

INCLUDE AREA CODE

POLICY / GROUP # _____ ID/SUBSCRIBER # _____

PRIMARY INSURED _____ SS # or ID # _____

HAVE YOU HAD ANY OUTPATIENT PHYSICAL THERAPY THIS YEAR FOR PRESENT ILLNESS/INJURY? ____ Y ____ N

HAVE YOU HAD ANY OUTPATIENT PHYSICAL THERAPY THIS YEAR FOR ANOTHER ILLNESS/INJURY? ____ Y ____ N

IF SO, WHERE AND FOR HOW LONG? _____ \$ _____

ARE YOU HAVING ANY TYPE OF HOME HEALTH CARE AT THE PRESENT TIME? ____ YES ____ NO

HAVE YOU HAD ANY HOME HEALTH CARE THIS YEAR? ____ YES ____ NO

IS ANYONE COMING TO YOUR HOME FOR ANY HEALTH SERVICES? ____ YES ____ NO

IF SO LIST AGENCY _____ AGENCY PHONE _____

IS YOUR VISIT TODAY RELATED TO AN AUTO ACCIDENT? ____ YES ____ NO