PRESSLER
PHYSICAL THERAPY CLINIC

402 West Wheatland Road, Suite 100
Duncanville, TX 75116

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TODAY'S DATE ___/___/_____ EMAIL _____

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

DESCRIPTION OF PAST MEDICAL PROBLEMS/ SURGERY _____

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

ACCT # _____ INS. CODE _____

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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 ☐ N0

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

ACCT # _____ INS. CODE _____