Confidential Medical History/Evaluation

First Name: _____ **Middle Name:**_____ **Last Name:**_____

Gender: Male / Female **Date of Birth:** _____ Social Security:_____

Address:_____ **City:**_____ **Zip Code:**_____

Email:_____ **Phone #:** _____How did you hear about us?_____

Guarantor Name:_____ Phone #:_____

Address:_____ Email:_____

Emergency Contact:_____ Relation:_____ Phone #: _____

Did you have any Physical Therapy this year? Yes ____ No _____ Currently Employed? Yes ____ No _____

Employer Name: _____Occupation:_____

Address: _____ Phone #:_____

Primary MD:_____ **Phone #:**_____

Referring MD:_____ **Phone #:**_____

Insurance Name:_____ **ID #:**_____

Secondary Insurance Name:_____ **ID #:**_____

Did you receive Home Health Care Services in the last 90 days? Yes ____ No _____

Is this Injury: Work Related Auto Accident **Date of Injury:** _____

Workers Comp: Insurance Name:_____ Phone #:_____

Claim #:_____ Adjuster Name:_____

Auto Accident: Insurance Name:_____ Phone #:_____

Claim #:_____ Phone #:_____

Attorney Information: Name:_____ Phone #:_____

Address:_____ Email:_____

Chief Complaint:_____

Current Symptoms: ***Pain*** ***Numbness*** ***Stiffness*** ***Weakness*** **Condition:** ***New*** ***Acute*** ***Chronic***

List any/all medications you are currently taking:_____

Are you allergic to any medications?_____

List any surgeries:_____

Have you had any Diagnostic or Rehabilitative Services for this Injury? MRI X-rays Other: _____

Do you have any of the following?

	YES	NO
Asthma, Bronchitis or Emphysema	_____	_____
Shortness of Breath/Chest Pain	_____	_____
Coronary Heart Disease	_____	_____
Do you have a Pacemaker?	_____	_____
High Blood Pressure	_____	_____
Heart Attack/Surgery	_____	_____
Stroke/TIA	_____	_____
Blood Clot/Emboli	_____	_____
Epilepsy/Seizures	_____	_____
Thyroid Trouble/Goiter	_____	_____
Anemia	_____	_____
Infectious Disease	_____	_____
Diabetes	_____	_____
Cancer or Chemo/Radiation	_____	_____
Arthritis/Swollen Joints	_____	_____
Osteoporosis	_____	_____
Varicose Veins	_____	_____
Gout	_____	_____
Sleeping Difficulties	_____	_____
Emotional/Psychological Problems	_____	_____
Bowel or Bladder Problems	_____	_____
Severe/Frequent Headaches	_____	_____
Vision/Hearing Difficulties	_____	_____
Dizziness or Faintness	_____	_____
Are you pregnant?	_____	_____

Smoking Daily_____ Weekly_____

Alcohol Consumption Daily_____ Weekly_____

Other Medical Conditions_____

Are you aware of your Diagnosis? Yes____No____ Are you aware of your Prognosis? Yes____ No____

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize the release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize the release of payment directly to Stay Ready Inc. regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs incurred.

Patient/Parent Guardian Signature:_____**Date:**_____