

**BODY BASICS PHYSICAL THERAPY PATIENT DATA SHEET**

**First:** \_\_\_\_\_ **MI:** \_\_\_\_\_ **Last:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Gender:** Male  Female

**Physical Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**Mailing Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<b>Phone Numbers:</b>	<b>OK To Call</b>	<b>Best Time To Call</b>
Home: _____	<input type="checkbox"/>	_____
Work: _____	<input type="checkbox"/>	_____
Cell: _____	<input type="checkbox"/>	_____

**May we send you text messages for your appointment reminders to the number(s) listed above?**  Yes  No

**May we send you text messages for Marketing Materials, including Patient review requests to the number(s) listed above?**  Yes  No

**By marking "Yes" above, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information**

**May we send you emails relating to your care with us?**  Yes  No  
**By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.**  
**Email:** \_\_\_\_\_

**Preferred language:** \_\_\_\_\_ **Interpreter required?**  Yes

**Date of Injury:** \_\_\_\_\_ **Referring Physician:** \_\_\_\_\_  
**Injury Area:** \_\_\_\_\_ **Auto or Work Accident:**  Auto  Work  N/A

**State Where Accident Occured:** \_\_\_\_\_  
**Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc) in the last 60 days?**  Yes  No

**Are you currently receiving or have you received other therapy services in the last 60 days?**  Yes  No

**Marital Status:**  
 Married  Single  Divorced  Widowed  Separated  Unknown

**Student Status:**  
 Full-Time  Part-Time  None

**EMPLOYMENT STATUS**

**Employment Status:**

Active Military    Full-Time    None    Part-Time    Retired    Self Employed

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance:** \_\_\_\_\_

**Policy Holder's Name:** \_\_\_\_\_ **Holder's Birth Date:** \_\_\_\_\_

**Policy or Certificate #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Policy Holder's Employer:** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

**Policy Holder's Name:** \_\_\_\_\_ **Holder's Birth Date:** \_\_\_\_\_

**Policy or Certificate #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Policy Holder's Employer:** \_\_\_\_\_

**How did you hear about us?**

- |                                         |                                                 |                                                             |
|-----------------------------------------|-------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Physician      | <input type="checkbox"/> Hospital               | <input type="checkbox"/> Marketing Ad - Print               |
| <input type="checkbox"/> Employer       | <input type="checkbox"/> Cross Referral         | <input type="checkbox"/> Marketing Ad - TV                  |
| <input type="checkbox"/> Case Manager   | <input type="checkbox"/> Friend - Word of Mouth | <input type="checkbox"/> Marketing Ad - Billboard           |
| <input type="checkbox"/> Former Patient | <input type="checkbox"/> Attorney               | <input type="checkbox"/> Marketing Ad - Direct Mail - Email |
| <input type="checkbox"/> Adjustor       | <input type="checkbox"/> Self                   | <input type="checkbox"/> Marketing Ad - Facebook            |
| <input type="checkbox"/> School         | <input type="checkbox"/> Screens - Open Houses  | <input type="checkbox"/> Marketing Ad - Other _____         |

Specify if other : \_\_\_\_\_

**Note: Please provide us with the most updated information below.**

**EMERGENCY AND OTHER CONTACTS**

Name	Phone	Work	Cell	Fax	Type

**DISCLOSURE OF MEDICAL RECORDS**

I authorize the following individuals to have access to my medical and billing records:

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date



## BODY BASICS PHYSICAL THERPAY MEDICAL HISTORY FORM

PATIENT NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_  
 REFERRING PHYSICIAN'S NAME: \_\_\_\_\_ DATE OF INJURY OR ONSET: \_\_\_\_\_  
 PRIMARY CARE PHYSICIAN'S NAME: \_\_\_\_\_ ARE YOU PRESENTLY WORKING? YES NO  
 CAUSE OF INJURY OR ONSET: \_\_\_\_\_ DATE OF NEXT MD APPT: \_\_\_\_\_

DO YOU CURRENTLY HAVE ANY "FLU TYPE" SYMPTOMS (I.E. FEVER, COUGHING)? YES NO  
 IF YES, WHAT SYMPTOMS: \_\_\_\_\_

DO YOU HAVE ANY OPEN CUTS, LESIONS OR WOUNDS? YES NO IF YES, WHERE: \_\_\_\_\_

HAVE YOU FALLEN IN THE PAST YEAR? (circle one) YES NO IF YES, HOW MANY TIMES: \_\_\_\_\_

IF YES TO FALLING, DID YOU SUSTAIN AN INJURY AS RESULT OF THE FALL? YES NO \_\_\_\_\_

WHAT IS YOUR REASON FOR ATTENDING THERAPY: \_\_\_\_\_

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR

DO YOU USE TOBACCO? (circle one) YES NO, IF YES, HOW MUCH? \_\_\_\_\_ WEAR GLASSES / CONTACTS?: YES NO

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO IF YES, WHEN \_\_\_\_\_  
 AND WHY \_\_\_\_\_

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one) YES NO  
 WHAT WAS DONE? / WHAT WERE THE RESULTS?: \_\_\_\_\_

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO  
 WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH  
 FOR HOW LONG? \_\_\_\_\_

CURRENT MEDICATIONS: \_\_\_\_\_

ALLERGIES: Medication \_\_\_\_\_ Reaction \_\_\_\_\_ Other \_\_\_\_\_ Reaction \_\_\_\_\_

ARE YOU ALLERGIC TO LATEX? (circle one) YES NO If yes what is the Reaction \_\_\_\_\_

Are you Allergic to Dexamethasone? YES NO If yes what is the Reaction \_\_\_\_\_

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

- |                                                                                                                        |                                                                                                             |                                                                                                             |
|------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> ANEMIA                                                                                        | <input type="checkbox"/> DIABETES <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled | <input type="checkbox"/> RESPIRATORY PROBLEMS                                                               |
| <input type="checkbox"/> ARTHRITIS                                                                                     | <input type="checkbox"/> DEPRESSION                                                                         | <input type="checkbox"/> ASTHMA <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled   |
| <input type="checkbox"/> CANCER                                                                                        | <input type="checkbox"/> DIZZINESS/FAINTING                                                                 | <input type="checkbox"/> COPD <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled     |
| <input type="checkbox"/> CARDIOVASCULAR PROBLEMS                                                                       | <input type="checkbox"/> FRACTURES                                                                          | <input type="checkbox"/> Other                                                                              |
| <input type="checkbox"/> HOLTER MONITOR - currently wearing?                                                           | <input type="checkbox"/> HEADACHES                                                                          | <input type="checkbox"/> SEIZURES <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> PACEMAKER                                                                                     | <input type="checkbox"/> HEPATITIS/HIV                                                                      | <input type="checkbox"/> THYROID PROBLEMS                                                                   |
| <input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled | <input type="checkbox"/> KIDNEY PROBLEMS                                                                    | <input type="checkbox"/> BLOOD THINNERS (Anticoagulants)                                                    |
| <input type="checkbox"/> LOW BLOOD PRESSURE                                                                            | <input type="checkbox"/> MRSA (Methicillin Resistant Staphylococcus Aureus)                                 |                                                                                                             |
| <input type="checkbox"/> CURRENTLY PREGNANT                                                                            | <input type="checkbox"/> OSTEOPOROSIS                                                                       |                                                                                                             |

If checked any above, explain: \_\_\_\_\_

ANY OTHER MEDICAL PROBLEMS: \_\_\_\_\_

SIGNATURE OF PATIENT: \_\_\_\_\_ REVIEWED BY Therapist: \_\_\_\_\_ Date \_\_\_\_\_

This form constitutes proprietary information and cannot be used, reproduced or duplicated, in whole or in part, absent written consent of BODY BASICS PHYSICAL THERAPY. This form must be completed in its entirety and must be provided to BODY BASICS PHYSICAL THERAPY prior to initiation of therapy services. **Revised 4.16.15 KB**