Medical Summary Form

Name: _____ Age: _____

Describe your symptoms: _____

How long have you been experiencing these symptoms: _____

Do you currently have or have you ever had one of the following:

YES	NO		YES	NO		YES	NO		
☐	☐	Diabetes	☐	☐	Epilepsy/Seizures	☐	☐	Lung condition	Describe:
☐	☐	High Blood Pressure	☐	☐	Migraine Headaches				_____
☐	☐	Dizziness or vertigo	☐	☐	Allergies				_____
☐	☐	Pacemaker	☐	☐	Osteoporosis	☐	☐	Heart condition	Describe:
☐	☐	Infectious Diseases	☐	☐	Arthritis				_____
☐	☐	Cancer	☐	☐	Allergy to latex				_____

	YES	NO	
Do you have any difficulty walking?	☐	☐	
Have you had any recent change in your weight or appetite?	☐	☐	Height_____ Weight_____
Do you have any intolerance to hot or cold?	☐	☐	BMI _____
Do you have any bruising or bleeding disorders?	☐	☐	
Do you have a history of falls?	☐	☐	how many in last year?_____
Do you feel unsteady and fear falling?	☐	☐	

In general would you say your overall health right now is: excellent / very good / good / fair / poor

Do you engage in regular exercise? YES ☐ NO ☐ What type and how often? _____

What is your occupation? _____

☐ Active ☐ Inactive ☐ Heavy Work

In general is your lifestyle ☐ Active ☐ Average ☐ Inactive

When you take a walk or climb stairs, do you ever have to stop because of pain in your chest, shortness of breathe or because you are very tired? YES ☐ NO ☐

Is there a chance you may be pregnant at this time? YES ☐ NO ☐

Do you smoke?_____ Cigar/Cigarette/Pipe How much? _____ Quit when? _____

What are your goals for therapy? _____

Have you seen a physical therapist for treatment of this condition? ☐ YES ☐ NO

Are you presently receiving chiropractic or any other alternative therapy at this time? ☐ YES ☐ NO

Patient Signature _____ Date _____ P.T. _____

2/19/2014

PRESCRIPTION MEDICATIONS

List all prescribed medication that you are currently taking.

Name	Prescribing doctor's name	Reason for taking the medication	Dose (ie. 2mg, 1 tsp)	How often? (ie. 3x/day)

NON-PRESCRIPTION MEDICATIONS, VITAMINS AND SUPPLEMENTS

List all those you take occasionally, such as aspirin for headaches, as well as those you take every day, such as a multivitamin or nutritional supplement, including any herbs or alternative medicines that you take.

Name	Reason for taking the medication	Dose (ie. 2mg, 1 tsp)	How often? (ie. 3x/day)

Signature

Date

P.T. Initial: _____

PHYSICAL THERAPY GROUP OF WESTCHESTER

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____

CITY/STATE: _____ ZIP CODE: _____

HOME #:(____)_____-_____CELL #:(____)_____-_____ WORK #:(____)_____-_____

DATE OF BIRTH: _____ GENDER: _____

NAME/ADDRESS OF EMPLOYER: _____

IS YOUR CONDITION A RESULT OF A WORK RELATED INJURY? YES / NO

IS YOUR CONDITION A RESULT OF AN AUTOMOBILE ACCIDENT? YES / NO

PRIMARY INSURANCE: _____ ID#: _____

SECONDARY INSURANCE: _____ ID#: _____

NAME OF INSURED: _____ D.O.B. OF INSURED: _____

INSURED'S EMPLOYER: _____

ADDRESS: _____

REFERRING PHYSICIAN: _____ TEL #: _____

PRIMARY CARE PHYSICIAN: _____ TEL #: _____

EMERGENCY CONTACT: _____ TEL #: _____

RELATIONSHIP: _____

HOW DID YOU LEARN ABOUT OUR OFFICE?: _____

HAVE YOU RECEIVED ANY PHYSICAL/SPEECH THERAPY THIS YEAR? YES / NO

ARE YOU ENROLLED IN A HOMECARE PROGRAM? YES / NO

INSURED / AUTHORIZED SIGNATURE: _____ DATE: _____

Patient Name: _____ Date: _____

AUTHORIZATION FOR USE OF SIGNATURE ON FILE AND ASSIGNMENT OF BENEFITS

RELEASE AND ASSIGNMENT OF BENEFITS

I hereby authorize the Physical Therapy Group of Westchester (PTGW) to mark the section Authorized Person's signature with the notion signature on file and to bill my insurance company directly for the covered portions of charges. I authorize payment of medical benefits directly to PTGW. I authorize PTGW to release medical or other information necessary to process this claim. I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible and co-payment. I understand that some insurance carriers require medical or administrative preauthorization for treatment, or have reimbursement limits on physical therapy treatment. I understand that I am responsible for knowing and meeting the requirements of my insurance plan.

_____ _____

Signature of patient or guardian Date

ACKNOWLEGDEMENT OF PRIVACY PRACTICES

I acknowledge that I have received and reviewed the Notice of Privacy Practices. If I have any questions, I can contact the Physical Therapy Group of Westchester, P.C. to discuss my concerns.

_____ _____

Signature of patient or guardian Date

CANCELLATION POLICY

Our office requires a **24 hour notice** if you are unable to keep your appointment. Please be advised a **$50.00 fee** will be charged for no shows and cancellations that are less than 24 hours. The fee is your responsibility and will not be paid by your insurance company. We appreciate your cooperation in helping us to provide excellent therapy services to our patients.

_____ _____

Signature of patient or guardian Date