

Welcome Form

Date: _____ SS#: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____

State: _____ Zip: _____ Birth date: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact Name: _____ Emergency Phone: _____

Occupation: _____ Employer: _____

Email: _____

It is **strongly** encouraged that you list your email so that our office may send you pertinent information like home exercise programs and videos, insurance updates, or monthly newsletters.

Sex: Male Female Marital Status: Married Widowed Single Divorced Partnered

Spouse's Name: _____ Spouse's Birth date: _____

Who is the responsible insurance party for this account: _____

Whom may we thank for referring you: _____

Have you been injured as a result of a fall in the past year? Yes No Two or more falls in the last year? Yes No

May we send you text messages or emails for appointment reminders: Yes, Email Text No, I prefer calls

Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No	Depression: <input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis: <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia: <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes: <input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis: <input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety: <input type="checkbox"/> Yes <input type="checkbox"/> No	Dizzy Spells: <input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's: <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis: <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema/Bronchitis: <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis: <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma: <input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures: <input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures: <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer: <input type="checkbox"/> Yes <input type="checkbox"/> No	Gallbladder Problems: <input type="checkbox"/> Yes <input type="checkbox"/> No	Speech Problems: <input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Conditions: <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis: <input type="checkbox"/> Yes <input type="checkbox"/> No	Strokes: <input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Pacemaker: <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure: <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease: <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency: <input type="checkbox"/> Yes <input type="checkbox"/> No	Incontinence: <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis: <input type="checkbox"/> Yes <input type="checkbox"/> No
Circulation Problems: <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems: <input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Problems: <input type="checkbox"/> Yes <input type="checkbox"/> No
Currently Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No	Metal Implants: <input type="checkbox"/> Yes <input type="checkbox"/> No	Other: <input type="checkbox"/> Yes <input type="checkbox"/> No

Medical History

Notes: _____

Medications Currently Taking (dosages and reasons taking): _____

Surgical History (Body Part, Surgery Type, When): _____

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services. I also request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made to either me or on my behalf to Gina's Physical Therapy, Inc. for any services furnished to me by the provider.

Signature of Beneficiary, Guardian or Personal Representative: _____

Please print name of Beneficiary, Guardian or Personal Representative: _____

Date: _____ Relationship to patient: _____