Confidential Medical History/Evaluation **Southern Physical and Occupational Therapy Services, Inc.**

Name: _____ Date: _____
Last First Middle Initial

Address: _____
City State Zip Code

Home Phone: _____ Cell Phone: _____

Email: _____

Place of Employment: _____ Work Phone: _____

Birth Date: _____ Age: _____ SSN: _____ Gender: _____ Male _____ Female

Marital Status: Married _____ Single _____ Divorced _____ Widowed _____ Spouse's Name: _____

Place of Spouse's Employment: _____ Work Phone: _____

In case of emergency, please contact: _____ Phone: _____

Person responsible for payment of account if other than yourself:

_____
Last First Middle Initial DOB Relationship to Patient

Responsible Person's Street Address: _____ City: _____ Zip: _____

Responsible Person's Place of Employment: _____ Work Phone: _____

Place of Parent of Guardian's Employment: _____ Work Phone: _____

Primary Insurance

Insured ID#: _____
Group #: _____
Insured SSN: _____

Secondary Insurance

Insured ID#: _____
Group#: _____
Insured SSN: _____

Name of Referring Doctor: _____ Dr.'s Phone: _____

Is this injury? _____ Work Related _____ Auto Accident Next Dr.'s visit: _____ Onset of injury: _____

Chief Complaint: _____ Date of Surgery: _____

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

Are you allergic to any medications? _____
List any surgeries: _____

Medicare Patients: Are you receiving Home Health Services? _____ Yes _____ No

Do you have any of the following?	**Yes**	**No**		**Yes**	**No**
Asthma, Bronchitis or Emphysema			Arthritis/Swollen Joints		
Shortness of Breath/Chest Pain			Osteoporosis		
Coronary Heart Disease			Varicose Veins		
Do you have a Pacemaker			Gout		
High Blood Pressure			Sleeping Difficulties		
Heart Attach/Surgery			Emotional/Psychological Problems		
Stoke/TIA			Bowel of Bladder Problems		
Blood Clot/Emboli			Severs/Frequent Headaches		
Epilepsy/Seizures			Vision/Hearing Difficulties		
Thyroid Trouble/Goiter			Dizziness or Faintness		
Anemia			Are you Pregnant?		
Infectious Disease			Smoking	Daily _____	Weekly _____
Diabetes			Alcohol Consumption	Daily _____	Weekly _____
Cancer of Chemo/Radiation					

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 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 release of payment directly to Southern Physical and Occupational Therapy Services, Inc. regardless of participation in or out-of-network. Should I default on my financial responsibility and collection actions is necessary, I will be responsible for collection costs that are incurred.
I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient/Parent/Guardian Signature_____ Date_____