Patient Information

Date:	Last Name:	First Name:	Middle Name:	Age:
Address: Street:	City:	State/Zip:	Home Phone:	
Email Address:			Soc. Security No:	
Female ( ) Birth Date:		Single ( ) Married ( ) Separated ( ) Divorced ( )		
Male ( ) Driver's Lic. No.:				
Employer Name:	Employer Address:	Work Phone:		
Occupation:	Have you been a patient before?	Approximately when?		
Responsible party if other than patient:	Soc. Security No.:	Home Phone:		
Address: Street:	City:	State/Zip:		
Employer Name:	Employer Address:	Work Phone:		
Referred by: Patient ( ) Doctor ( ) Coaching Staff ( ) Other ( ) (Please specify person) **Internet/Webpage ( ) Yellow Pages ( )**				
Nearest Friend or Relative not living with you:	Address:	Home Phone:		
Physician Name:		Physician Phone Number		
Physician Address: Street:	City	State/Zip:		
If you were injured, were you injured: On Your Job ( ) Auto Accident ( ) At Home ( ) Date of Injury:				
Are you off work because of this injury:		Date Last Worked:		
Attorney:	Address:	Phone:		

Assignment of Benefits

I hereby irrevocably assign the insurance benefit payment, both basic and major medical, to which I am entitled directly to SYNERGY PHYSICAL THERAPY & SPORTS PERFORMANCE rendering services.

X Insured signature: _____ Witness: _____ Date: _____

Medical History

(Federal regulations require a medical history to be included in all patients' medical records)

Patients Name:_____ Date: _____

Date of Injury _____ Date of Surgery _____

Reason for Physical Therapy: _____

Have you had previous therapy for your present condition for which you are to receive treatment here?
Yes ___ No ____ If yes, state where/when: _____

Do you now have/or ever had any of the following:

Diabetes	Yes	No	Sensitive Heat/Ice	Yes	No	
High Blood Pressure	Yes	No	Pregnant	Yes	No	Now
Heart Disease	Yes	No	Other Allergies	Yes	No	
Heart Attack	Yes	No	Previous Surgery	Yes	No	
Pacemaker	Yes	No	Hernia	Yes	No	
Headaches (chronic)	Yes	No	Seizures	Yes	No	
Kidney Problems	Yes	No	Metal Implants	Yes	No	
Nervous Disorders	Yes	No	Cancer	Yes	No	
			Other Condition _____			

If yes on any above, please explain and give approximate dates: _____

_____

Are you presently taking any medication? Yes ___ No ___ If yes, list what medications and for what condition: _____

_____

The above information is correct to the best of my knowledge.

_____ _____
Patient Signature Date

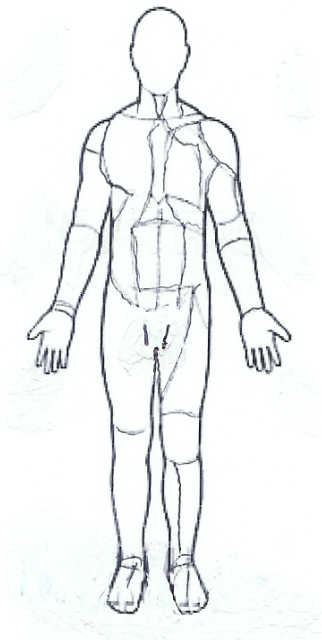
_____ _____
Witness Date

Patient Name: _____

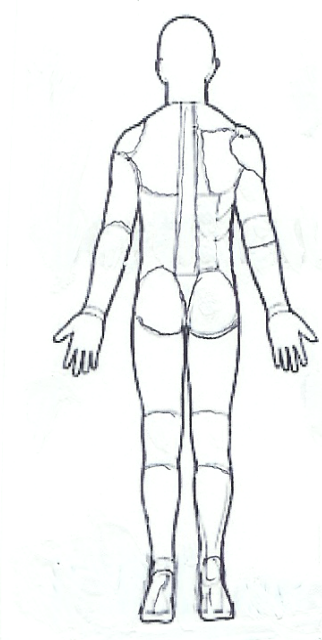
Date: _____

Indicate on the body chart below the location of your injury or condition. If able please write the quality of your injury, condition or pain. (i.e. ache, sharp, weakness, etc.)

Front View



Back View



On a scale of 0 (no pain) to 10 (unbearable pain), please indicate the range of your discomfort: 0 5 10 **No Pain** **Unbearable**
How did injury occur:
Headaches: Yes No *Night Pain/Disturbed Sleep: Yes No*
Symptoms are aggravated by:
Symptoms are eased by:
Activities you are currently unable to do because of your injury:
Comments/Goals: