PATIENT INFORMATION & BRIEF HISTORY • KEVIN SNIDER PHYSICAL THERAPY

(Federal regulations require a medical history must be included in all patients' medical records in this office)

Date________________ Referring Physician________________

PATIENT'S NAME________________ Age______ Birthdate________

Address________________ City__________ Zip________

Home Phone __________ Cell Phone __________ SSN __________

Male ☐ Female ☐ Child ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐

Employer________________ Phone________

Employer's Address________________ Occupation________

☐ SPOUSE
☐ MOTHER
☐ FATHER

Name____________ S.S. No.__________ Age____ Birthdate________

Employed by________________ Phone________

Employer's Address________________ Occupation________

Mail Statements to________________ Address________________

Emergency Contact ____________ Relationship to patient __________ Phone________

Date of Injury/Onset__________ How Happened________________ Date of Surgery__________

Is this a work related injury or condition? Yes ☐ No ☐

Is your injury related to a motor vehicle accident? Yes ☐ No ☐

How did you hear about us? ___ Relative ___ Friend ___ Physician ___ Patient of KSPT ___ Advertising

Attorney________________ Address ________________ Phone ________

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

	Yes	No		Yes	No		Yes	No
Diabetes	☐	☐	Headaches............	☐	☐	Previous Surgery............	☐	☐
High Blood Pressure	☐	☐	Kidney Problems	☐	☐	Hernia (Ventral, Inguinal, etc)....	☐	☐
Heart Disease	☐	☐	Nervous Disorders	☐	☐	Seizures	☐	☐
Heart Attack	☐	☐	Allergies to Heat or Ice Packs ...	☐	☐	Metal Implants	☐	☐
Pacemaker	☐	☐	Cancer Episode............	☐	☐	Other Allergies Including............ Tapes, Gels, Lotions	☐	☐

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

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Are you presently taking medication? Yes ☐ No ☐ If yes, please list what medications and for what condition________

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Have you had previous physical therapy for your present condition for which you are to receive treatment here? Yes ☐ No ☐

If yes, state where, when, and what treatment was given ________________

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The above information is correct to the best of my knowledge.
I agree that ***Kevin Snider Physical Therapy*** *may furnish the insurance company and/or the person authorized by law with whatever information it desires concerning said physical services.*

I also agree that any monies received from my insurance company over and above my indebtedness will be refunded when my bill is paid in full. I understand that I am financially responsible for all charges not covered by insurance. I will be responsible to the PHYSICAL THERAPIST for payment of the entire bill. I also understand that I am financially responsible for all cost of collection, including reasonable attorney's fees and court cost.

WITH MY SIGNATURE I also give my consent to ***Kevin Snider Physical Therapy*** *to administer the physical therapy as outlined by my physician, and hereby authorize payment from my insurance companies directly to* ***Kevin Snider Physical Therapy****. A monthly bookkeeping charge will be added to accounts reflecting a 30-day-old- balance.*

DATED ________________, 20 ______ PATIENT ________________

WITNESS ________________ POLICYHOLDER ________________