

## Walton Physical Therapy

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

### Patient Information

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated  
Patient's Employer or School \_\_\_\_\_ Work Phone \_\_\_\_\_

Person to Contact in case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

Have You Been Treated in Our Office in the Past?  Yes  No

### Responsible Party

Name of Person Responsible for This Account \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Employer \_\_\_\_\_ Work /Cell Phone \_\_\_\_\_

### Referral Information

What Physician Referred You to Our Clinic: \_\_\_\_\_

How Did You Hear About Us:  Club Sport Member  Website  Yellow Pages  Friend \_\_\_\_\_  
 Event / Race \_\_\_\_\_  Other \_\_\_\_\_

### Private Insurance Information

Insurance Carrier \_\_\_\_\_ Phone \_\_\_\_\_  
Subscriber I.D. # \_\_\_\_\_ Group / Policy # \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Do You Have Any Additional / Secondary Insurance?  Yes  No

### Worker's Comp / Auto Insurance information

Insurance Carrier \_\_\_\_\_ Employer \_\_\_\_\_  
Claim # \_\_\_\_\_ Date of Accident \_\_\_\_\_ State \_\_\_\_\_  
Adjuster \_\_\_\_\_ Phone Number \_\_\_\_\_

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Walton Physical Therapy's Cancellation Policy requires that at least 12 hours advance notice be given on all cancelled appointments. By signing below you acknowledge that you understand this cancellation policy and agree to give sufficient notice on all canceled appointments.

X \_\_\_\_\_  
Signature of Patient or Parent if Minor

\_\_\_\_\_  
Date

**Chief Complaint** - describe the problem(s) for which you are seeking treatment:

**Medications** – please list all prescription and nonprescription medications taken

**Previous Surgery / Hospitalization** – please note the date of the surgery / hospitalization

**Current Condition** – have you had problems with any of the following in the past 12 months?

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Chest Pain or Angina     | <input type="checkbox"/> Convulsions or Seizures | <input type="checkbox"/> Nausea / Vomiting     | <input type="checkbox"/> Depression            |
| <input type="checkbox"/> Palpitation              | <input type="checkbox"/> Balance / Coordination  | <input type="checkbox"/> Urinary Problems      | <input type="checkbox"/> Memory Loss           |
| <input type="checkbox"/> Shortness of Breath      | <input type="checkbox"/> Joint Pain / Stiffness  | <input type="checkbox"/> Bowel Problems        | <input type="checkbox"/> Confusion             |
| <input type="checkbox"/> Wheezing                 | <input type="checkbox"/> Swelling of Joints      | <input type="checkbox"/> Eyes / vision         | <input type="checkbox"/> Nervousness / Anxiety |
| <input type="checkbox"/> Chronic / Frequent Cough | <input type="checkbox"/> Muscle Pain or Cramps   | <input type="checkbox"/> Ears / Hearing        | <input type="checkbox"/> Difficulty Sleeping   |
| <input type="checkbox"/> Fever / Sweats / Chills  | <input type="checkbox"/> Muscle Weakness         | <input type="checkbox"/> Nose / Mouth / Throat | <input type="checkbox"/> Sexual Difficulty     |
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Numbness or Tingling    | <input type="checkbox"/> Skin Rash             | <input type="checkbox"/> Male-Prostate         |
| <input type="checkbox"/> Excessive Fatigue        | <input type="checkbox"/> Weight Gain / Loss      | <input type="checkbox"/> Infections            | <input type="checkbox"/> Female-Menstrual      |
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Loss of Appetite        | <input type="checkbox"/> Bleeding / Bruising   | <input type="checkbox"/> Other Condition       |
| <input type="checkbox"/> Blackouts                | <input type="checkbox"/> Difficulty Walking      | <input type="checkbox"/> Gland / Hormone       | _____  |

**List any clinical tests you have had in the past 12 months** - Angiogram, CT Scan, EKG, Etc.

**Medical History** – Have You Ever Had The Following

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Broken / Fractured Bone | <input type="checkbox"/> Muscular Dystrophy  | <input type="checkbox"/> Blood Disorder      | <input type="checkbox"/> AIDS or HIV +      |
| <input type="checkbox"/> Head Injury             | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Thyroid Problem     | <input type="checkbox"/> Asthma / Allergies |
| <input type="checkbox"/> Spine Injury            | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Kidney Problem      | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Back Trouble            | <input type="checkbox"/> Heart Problem       | <input type="checkbox"/> Bladder Problem     | <input type="checkbox"/> Depression         |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Circulation Problem | <input type="checkbox"/> Stomach Problem     | <input type="checkbox"/> Other Condition    |
| <input type="checkbox"/> Osteoporosis            | <input type="checkbox"/> Respiratory Problem | <input type="checkbox"/> Eye Disease         | _____                                       |
| <input type="checkbox"/> Polio                   | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Disease        | _____                                       |
| <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Low Blood Pressure  | <input type="checkbox"/> Recurring Infection | _____                                       |
| <input type="checkbox"/> Parkinson Disease       | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Tuberculosis        | _____                                       |
| <input type="checkbox"/> Multiple Sclerosis      | <input type="checkbox"/> Low Blood Sugar     | <input type="checkbox"/> Hepatitis           | _____                                       |

**Consent For Care and Treatment:** I the undersigned, do hereby agree and give my consent for Walton Physical Therapy to furnish medical care and treatment to me (or my child) considered necessary and proper in diagnosing or treating my (or his/her) condition.

X \_\_\_\_\_  
Signature of Patient or Parent if Minor

\_\_\_\_\_  
Date