

**Patient's Name** \_\_\_\_\_ SS# \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

PLEASE CIRCLE ONE:      MALE / FEMALE      SINGLE      MARRIED      DIVORCED      WIDOWED      MINOR

SPOUSE'S / GUARDIAN NAME \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_

**Employment Information**      (WORKERS' COMP. EMPLOYER AT TIME OF INJURY)

EMPLOYER'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

WORK PHONE \_\_\_\_\_ OCCUPATION \_\_\_\_\_

SPOUSE'S / GUARDIAN EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_

WORK PHONE \_\_\_\_\_ OCCUPATION \_\_\_\_\_

**Physician Information**

NAME OF REFERRING DOCTOR \_\_\_\_\_ PHONE \_\_\_\_\_

WHOM CAN WE THANK FOR REFERRING YOU TO US? \_\_\_\_\_

**Payment Information**

CIRCLE ONE:      INSURANCE      CASH      WORKERS' COMP.

**Joubert P.T. does not accept liens under any circumstance. Joubert P.T. is not participating with Medicare.**

**No-Show / Cancellation Policy**

I understand there will be a minimum charge of \$50 for no-show appointments or cancellations with less than 24 hours' notice.

**Financial Responsibility**

I am financially responsible for all charges incurred at Joubert P.T. Any portion of these charges not covered by my insurance company must be paid by me. I further understand that all insurance deductibles are my responsibility and any deductible applied to Joubert's charges will be paid directly by me to Joubert P.T.

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**Assignment of Benefits**

I hereby authorize my insurance benefits to be paid directly to Joubert P.T.

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**Authorization to Release Information**

I authorize Joubert P.T. to release any information required by my insurance company.

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**Please Note:**

If you are a member of a managed care insurance, HMO or PPO, it is your responsibility to know your policy provisions and to inform this office.

Please circle appropriate # on scale.

0 = No pain 10 = Severe pain

**Pain Scale 0-1-2-3-4-5-6-7-8-9-10**

1. Diagram on the body chart your area(s) of pain / symptoms.

2. How do you alleviate your symptoms?

3. List any movement or activity which **aggravates** your pain.

4. When did this injury start bothering you? (**Most RECENT**)

5. Is your injury work related, motor vehicle accident, recreational, other? **Please circle one.**

6. What was the SPECIFIC cause of injury or the series of events leading up to your visit today: \_\_\_\_\_

7. Describe how your symptoms change during day (i.e., better, same, worse, stiff)

Morning \_\_\_\_\_ Midday \_\_\_\_\_ Evening \_\_\_\_\_

8. Do you wake up during the night because of pain?  Yes If yes, how many times? \_\_\_\_\_  No

9. Age \_\_\_\_\_ 10. Occupation \_\_\_\_\_

11. Do you **exercise**, and if so, what do you do? \_\_\_\_\_

**MEDICAL HISTORY**

12. How is your general health? (**please circle**) Any cancer, cardiac problems, pacemaker, osteoporosis, diabetes, hypertension, depression, rheumatoid arthritis, other \_\_\_\_\_

13. Do you have any metal plates or screws?  Yes  No

14. Are you pregnant?  Yes  No

15. Do your symptoms increase when you cough or sneeze?  Yes  No

16. Any significant, unexplained weight loss over the past 2-3 months?  Yes  No

17. Have you experienced any bowel or bladder problems?  Yes  No

18. Have you had X-rays or an MRI? **Date (s)** \_\_\_\_\_  Yes  No

18. Do you experience any of the following?

Headaches  Yes  No

Lightheadedness  Yes  No

Nausea  Yes  No

Blurred vision  Yes  No

Numbness or tingling anywhere  Yes  No

Muscle cramping  Yes  No

20. Have you **ever taken** steroids or anticoagulants?  Yes  No

21. List any medications that you are **currently** taking: \_\_\_\_\_

**Past Medical History:** Prior surgeries or **ANY** medical history \_\_\_\_\_

THE ABOVE ANSWERS ARE CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature of patient or guardian \_\_\_\_\_ Date \_\_\_\_\_

