

SCOR PHYSICAL THERAPY

RETURNING PATIENT INFORMATION

****Please present your insurance card(s) for copying.****

Patient Name:		Date of Birth:	Age:	Sex:
E-mail Address :	Is this injury work related? :		Marital Status: Single Married Other	
Address:		City, State, Zip		
Home Phone:	Work/Cell Phone:	Employer:		
OK to leave message? Yes No	OK to leave message? Yes No			
Referring MD:		Primary Care MD:		
Emergency Contact:		Relationship:	Home Phone:	
Has there been any change in your health history since the last episode of care with us? Please explain:				

CANCELLATION POLICY and CONSENT TO TREAT

We at SCOR PHYSICAL THERAPY want to provide the best possible care for our patients and attending your scheduled appointments is a necessary part of the treatment process. If there is no notice of cancellation 24 hours before the scheduled appointment, a \$50 cancellation charge will be billed directly to the patient for each cancellation. If you do not show up for a scheduled appointment, this same \$50 charge will be assessed. By signing below, you acknowledge that you have read, understood and agree to abide by our cancellation policy as described. You also acknowledge the above patient information is correct to the best of your knowledge. I grant permission for the staff of SCOR PHYSICAL THERAPY to perform the procedures as prescribed by my physician including a physical therapy evaluation. During this evaluation, the nature of the procedures that will be performed as well as the potential risks of care will be explained to me. If I become ill while undergoing treatment, I give permission to the staff to administer treatments which they consider necessary to my well-being. My signature below indicates that I understand and give consent to be treated as explained above.		
Patient Signature:	Guardian's Signature: (If patient is <18 years old)	Date:

SCOR PHYSICAL THERAPY

Patient Medical History Form-For Clinic Use ONLY

Current Concern/Problem:				Date of Onset:			
I. Have you ever been diagnosed with any of the following conditions? FILL IN THE APPROPRIATE CIRCLES.							
1. Cancer:		Yes 0	Type(s), include date of diagnosis:				
2. Infection:		Yes	No	3. Cardiovascular:		Yes	No
Chronic Urinary Tract/Kidney Infection		0	0	Heart Disease:		0	0
Pneumonia		0	0	Deep Venous Thrombosis (DVT):		0	0
Bone/Joint Infection		0	0	Arterial Blockage of the Legs		0	0
Viral Conditions:		0	0	High Blood Pressure:		0	0
Other Infection: (Please List)		0	0	Stroke/TIA		0	0
I.				Other:			
4. General Medical Conditions:		Yes	No	4. General Medical Conditions:		Yes	No
Rheumatologic Disorders:		0	0	Osteoarthritis:(Wear-and-Tear Arthritis)		0	0
Lung Disorders:		0	0	Osteoporosis/Osteopenia:		0	0
Liver/Kidney Conditions:		0	0	Dizziness or falls:		0	0
Gastrointestinal Disorders:		0	0	Depression:		0	0
Neurological Disorders:		0	0	Bowel/Bladder Incontinence:		0	0
Anemia/Blood Disorders:		0	0	Headaches: (more than 1 per week)		0	0
Thyroid Conditions:		0	0	Vision or hearing difficulty		0	0
Gout:		0	0	Immunologic/Allergy Conditions:		0	0
Diabetes:		0	0	Genitourinary/Gynecologic Conditions		0	0
Dermatologic Conditions:		0	0	Other conditions:			
II. Please List All Medications Including Frequency and Dosage: (both over-the-counter and Prescribed)							
Frequency Dosage				Frequency Dosage			
1.				7.			
2.				8.			
3.				9.			
4.				10.			
5.				11.			
6.				12.			
III. Surgeries and/or Hospitalizations:				IV. Other Current Conditions:			
1.	Date:			1. Recent, unplanned weight loss?	Yes		
2.	Date:			2. Unexplained night pain?	0	0	
3.	Date:			3. Fevers or night sweats?	0	0	
4.	Date:			4. Nausea/Vomiting?	0	0	
5.	Date:			5. Unexplained weakness or fatigue?	0	0	
V. Health-Related Habits							
Smoking		Yes	No			Yes	No
If yes, < 1 pack/day?	0	0	Do you have a Pacemaker?		0	0	
If yes, > 1 pack /day?	0	0	Are you Latex Sensitive?		0	0	
Ice Sensitive?	0	0	Heat Sensitive?		0	0	
Previous experience with physical therapy?			0	How many falls have you had in the last year?		Are you currently pregnant? ____	

I affirm that the above information is accurate and true.

Patient Signature _____ Date _____ Therapist Review (Initials) _____