Confidential Medical History Evaluation

Lebanon Physical Therapy
& Rehabilitative Services
We Care
276-889-4090 | www.lebanonpt.com

Name: ______________________ DOB ____/____/____ Age: ______ SSN: ______________

Address: ______________________ City: ______________ State: _____ Zip: ________ Phone: __________

Cell Phone: ____________ Email: ______________ Emergency Contact: ______________

How did you hear about us? Doctor Self Family/Friend Facebook Billboard Website Sign Newspaper Other: ____________

Referring M.D. ______________________ Primary Care Physician: ______________________

Chief Complaint: ______________________ Date of Injury: __________ Date of Surgery: __________

Current Employer: ______________________ Employer Phone#: ______________

Is this injury work related? _____ Auto? _____ Other? _____

If work injury list Co. Insurer: ______________________ Case # ______________

List all medications you are currently taking: ______________________________________

Are you allergic to any medications? ______________________ List Surgeries: ______________

Have you had any X-rays, MRI for this condition? ____________ Are you receiving home health currently? ____________

Other Medical Conditions ______________________________________

Do you have any of the following	Yes	No	Do you have any of the following	Yes	No
Asthma, Bronchitis or Emphysema			Cancer or Chemo/Radiation		
Shortness of Breath/ Chest Pain			Arthritis/ Swollen Joints		
Coronary Heart Disease			Osteoporosis		
Do you have a Pacemaker			Varicose Veins		
High Blood Pressure			Gout		
Heart Attack/ Surgery			Sleeping Difficulty		
Stroke/ TIA			Emotional/ Psychological Problems		
Blood Clot/ Emboli			Bowel or Bladder Problems		
Epilepsy/ Seizures			Sever/ Frequent Headaches		
Thyroid Trouble/ Goiter			Vision/ Hearing Difficulties		
Anemia			Dizziness or Faintness		
Infectious Disease			Are you pregnant?		
Diabetes					

How often?	Daily	Weekly
Smoking		
Alcohol Consumption		

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any Medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Patient/Parent/Guardian Signature: ______________________ Date: ______________

I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient/Parent/Guardian Signature: ______________________ Date: ______________