WALTON
PHYSICAL THERAPY AND SPORTS MEDICINE

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 _____

Primary Phone_____ Secondary Phone_____ Email_____

Employer _____ Work Phone _____

Emergency Contact_____ Phone_____ Relationship_____

How did you hear about WPTSM? Who referred you to our office?_____

Your benefits may be affected by previous treatment elsewhere (visit limits, authorizations, etc.) Please note the number of physical therapy visits you've had this year and the clinic/facility_____

Parent / Guardian Information (If patient is under 18, please complete the following)

Name of Person Responsible for This Account _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Relationship to Patient _____ Employer _____ Work Phone _____

Primary Phone_____ Secondary Phone_____

Primary Insurance Information (Please inform us if you have a secondary insurance)

(Does not need to be completed if card was presented at front desk for scanning)

Primary Insurance_____ Policy/ID Number_____ Group Number_____

Policy Holder Full Name_____ Policy Holder DOB_____ Relation to Patient_____

Insurance Address_____ Insurance Phone_____

Work Injury / Accident Information

Accident Date_____ Claim Number _____ Accident Insurance Name_____

Adjuster Name_____Adjuster Phone_____

You're not done yet! This form continues onto the next page

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Physical therapy is typically prescribed twice a week for four to six weeks. The average length of your appointments will be approximately an hour. Wear or bring comfortable clothing, allowing access to the injured area. Please do not forget proper footwear.

Physical therapy is billed by the procedure performed at each visit. It is not billed by the hour. Therefore, charges may vary from visit to visit. An average physical therapy visit may be between $200.00 to $250.00.

Due to the nature of insurance billing and the number of prescribed visits, you will receive your bill from Walton Physical Therapy once a month. The bill will include a running balance for services processed by your insurance to date. Most insurance companies take 30 days to process claims. Please note you may receive your first bill after your have completed therapy.

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 have read and understand the information outlined above.

X_____ _____

Signature of Patient or Parent if Minor Date

We are happy to have you as our patient and look forward to working with you.

We truly value your recovery and experience at Walton Physical Therapy.

Thank you for filling out our paperwork. We understand your time is valuable.

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Chief complaint (problem for which you are receiving treatment):_____

Have you recently experienced any of the following? (Check all that apply)

- ☐ Urinary or bowel problems
- ☐ Nausea/vomiting
- ☐ Dizziness/lightheadedness
- ☐ Difficulty maintaining balance
- ☐ Fever/chills/sweats
- ☐ Weight loss/gain
- ☐ Shortness of breath
- ☐ Headaches
- ☐ Changes in appetite
- ☐ Pain at night
- ☐ Weakness/fatigue
- ☐ Difficulty swallowing
- ☐ Sexual Difficulty
- ☐ Prostate problems (Male)
- ☐ Menstrual problems (Female)

Have you ever been diagnosed with any of the following conditions? (Check all that apply)

- ☐ Cancer (type)_____
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Asthma
- ☐ Pacemaker
- ☐ Osteoporosis
- ☐ Chemical dependency
- ☐ Rheumatoid arthritis
- ☐ Stroke
- ☐ Depression
- ☐ Anemia
- ☐ Lung Problems
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Multiple Sclerosis
- ☐ Kidney/Liver problems
- ☐ Stomach Ulcers
- ☐ Epilepsy
- ☐ Parkinson's disease
- ☐ Allergies_____
- ☐ Other_____

Please list any current medications:_____

Are you currently taking blood thinning or anti-coagulant medications? YES/NO

Do you smoke? YES/NO

For Women: Are you currently pregnant or planning on becoming pregnant? YES/NO

Please list surgeries or other conditions requiring hospitalization in the last 12 months.

What clinical tests have you had related to your current condition? (X-ray, MRI, CT, etc.)

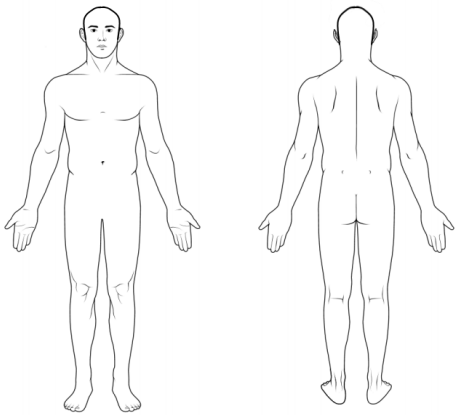
What activities are you unable to perform due to your condition? (ex. reaching overhead, stairs, running, sport)

What is your current pain level?

0 1 2 3 4 5 6 7 8 9 10

Body Chart:

Please mark the location of your pain.



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 my child's) condition.

X_____ _____

Signature of Patient (Parent if patient is a minor) Date