Rulin J. Hawks, PT

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Office 208/453-9111 Fax 208-453-9115

We are pleased to welcome you to our clinic. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help. We look forward to serving you!

Patient Information

Name:
LAST FIRST MI

Birth Date: **SSN:**

Address:
STREET

CITY STATE ZIP

Home Phone: **Cell:**

Emergency Contact:
NAME PHONE

Employer:

Work Phone:

Employer's Address:
STREET

CITY STATE ZIP

Contact at Employer:
NAME PHONE

Referred By:

Reason for Treatment:

Medical History

Injured Area:

Date of Injury/Onset:

Did this happen at work?

Date of Surgery:

Are you currently working:

Date of next Dr. appointment:

What activities are you having difficulty with as a result of your injury?

1

2

3

Please list your goals for physical therapy:

1

2

3

Do you feel your condition is:

Better **Worse** **Same**

Please rate your pain on a scale of 1-10: _____

Have you had physical therapy for this problem before? YES NO

Did it help? YES NO

Have you *ever* had physical therapy before?
YES NO

If so, what for and what was the result?

Please list any medical conditions for which you are under the care of a physician:

Please list all of your current medications:

Family Information

HUSBAND/FATHER (if minor)

LAST FIRST MI

ADDRESS:

STREET

CITY STATE ZIP

HOME PHONE: CELL:

EMPLOYER:

WIFE/MOTHER (if minor)

LAST FIRST MI

ADDRESS:

STREET

CITY STATE ZIP

HOME PHONE: CELL:

EMPLOYER:

Insurance Information

Primary Insurance Company:

ADDRESS:

STREET

CITY STATE ZIP

POLICY # GROUP #

INSURED'S NAME:

LAST FIRST MI

PATIENT'S RELATIONSHIP TO INSURED:

☐ Self ☐ Spouse ☐ Child ☐ Other _____

INSURED'S DATE OF BIRTH:

ADDRESS:

STREET

CITY STATE ZIP

INSURED'S EMPLOYER:

EMPLOYER'S ADDRESS:

STREET

CITY STATE ZIP

Secondary Insurance Company:

ADDRESS:

STREET

CITY STATE ZIP

POLICY # GROUP #

INSURED'S NAME:

LAST FIRST MI

PATIENT'S RELATIONSHIP TO INSURED:

☐ Self ☐ Spouse ☐ Child ☐ Other _____

INSURED'S DATE OF BIRTH:

ADDRESS:

STREET

CITY STATE ZIP

INSURED'S EMPLOYER:

EMPLOYER'S ADDRESS:

STREET

CITY STATE ZIP

Financial Information

Responsible Party

NAME:

LAST FIRST MI

DATE OF BIRTH:

SSN:

ADDRESS:

STREET

CITY STATE ZIP

EMPLOYER:

Consent

I have completed this questionnaire to the best of my ability.

I give my consent to receive treatment from Caldwell Physical Therapy.

I authorize Caldwell Physical Therapy to release my information and treatment records to my physician(s) and insurance company(ies).

I authorize insurance benefits to be paid directly to this office.

I have received a copy of this office's Privacy Practices.

X

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE

RELATIONSHIP TO PATIENT