RESTORATIVE THERAPY & WELLNESS LLC

We restore your movement™

Confidential Medical History/Evaluation

Name: _____ Date: _____

Address: _____

Date of Birth: ____/____/____ Age: _____ (H) Phone: _____ Cell #: _____

Last (4) SSN#: _____ Marital Status: S M D Other _____ Email Address: _____

Referring Physician: _____ Primary Care Physician:_____

Employer: _____ Phone: _____ Occupation: _____

Emergency Contact: _____

Approximate Date when condition began (mmddyyyy): ____/____/____

Is this an Injury? □ Yes or □ No Date of Injury: _____ Work Related? □ Yes or □ No Auto Accident? □ Yes or □ No

Chief Complaint: _____

Current Symptoms: _____ Pain _____ Numbness _____ Stiffness _____ Weakness

Have you had any Diagnostic or Rehabilitative Services for this injury? □ MRI □ X-Rays □ Therapy □ Other: _____

_____

List any surgeries, hospitalizations, and dates: _____

_____

Is your home an: □ Apt. □ Single Story □ 2 Story □ > 2 Story □ Other: _____

List all Medical Equipment in your home: (i.e.; Wheelchair, Walker, Reacher, Raised Toilet) _____

_____

Have you fallen in the past year? □ Yes or □ No

Are you currently participating or receiving any home health or nursing care services for this condition? □ Yes or □ No

What is your major goal in physical therapy now? _____

5881 GLENRIDGE DRIVE SUITE 170 ATLANTA, GA 30328
404-236-0934 (PHONE) 404-236-0935 (FAX)

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Confidential Medical History/Evaluation (page 2)

Name: _____ **Date:** _____

Do you have any of the following?	Yes	No		Pain when performing the following activities?	Mild	Moderate	Severe	Unable
Asthma, Bronchitis or Emphysema				Bending				
Shortness of Breath/Chest Pain				Care for Family Member				
Coronary Heart Disease				Carrying Groceries				
Do you have a Pacemaker				Change Position Sit to Stand				
High Blood Pressure				Climb Stairs				
Heart Attack/Surgery				Driving				
Stroke/TIA				Extended Computer Use				
Blood Clot/Embolism				Feeding (Self)				
Epilepsy/Seizures				Household Chores				
Thyroid Trouble/Goiter				Kneeling				
Anemia				Lifting Children				
Diabetes				Pet Care				
Cancer or Chemo/Radiation				Reading (Concentration)				
Arthritis/Swollen Joints				Self-Care Bathing				
Osteoporosis				Self-Care-Dressing				
Varicose Veins				Self-Care-Shaving				
Gout				Sexual Activities				
Sleeping Difficulties				Sleep				
Emotional/Psychological Problems				Sitting (Prolonged)				
Bowel or Bladder Problems				Standing (Prolonged)				
Severe/Frequent Headaches				Walking				
Vision/Hearing Difficulties				Yard Work				
Dizziness or Faintness				Sports				
Are you Pregnant				Recreational Activities				

Do you smoke □ Yes □ No (If "Yes", how much) Daily = _____ Weekly = _____

Do you exercise □ Yes □ No (If "Yes", how much) Daily = _____ Weekly = _____

Other Medical Conditions:

_____

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. I authorize release of payment directly to **Restorative Therapy & Wellness, LLC** regardless of participation in or out-of-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:** _____

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