BUNKER HILL PHYSICAL THERAPY

A Division of Jones Chiropractic and Physical Therapy, Ltd.

Patient Information

Patient Name: (First, MI, Last)	**Home Phone:**
Street Address:	**Work Phone:**
PO Box:	**Date of Birth:**
City, State, Zip:	**Soc. Sec. #:**
Sex: Male Female	**Marital Status: S M D W**
Employer:	**Occupation:**
Referring Physician:	**PCP** (Primary Care Physician) **:**

Responsible Party

Person Responsible for Account:	**Date of Birth:**
Relationship to Patient:	**Soc. Sec. #:**
Address: (if different than patient)	**Phone:**
City, State, Zip:	**Employer:**
Business Address:	**Business Phone:**

Emergency Contact Information

Name:	**Relationship:**
Address:	**Phone:**
City, State, Zip:	

Insurance Information

Primary Insurance:	**Secondary Insurance:**
Address:	**Address:**
City, State, Zip:	**City, State, Zip:**
Phone #:	**Phone #:**
Group/Claim #:	**Group/Claim #:**
Subscriber ID #:	**Subscriber ID #:**
Subscriber Name:	**Subscriber Name:**
Subscriber DOB:	**Subscriber DOB:**
Relationship:	**Relationship:**
Employer:	**Employer:**

Informed Consent for Clinic Care

A patient, in coming to the clinic, gives the *clinic* permission and authority to care for the patient in accordance with the *clinic* testing, treatment, and analysis. The treatment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, an underlying physical defect, deformity or pathology may render the patient susceptible to injury. The clinic will not give adjustments or treatment if the provider is aware that such care may be contra-indicated. Again it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the providers of the clinic. That patient should look to the correct specialist for the proper diagnostic and clinical procedure. The clinic provides a specialized, non-duplicating health service. The providers of the clinic are licensed in a special practice and are available to work with other types of providers in your health care regime.

I have furnished the condition of my health to the best of my knowledge to the providers and consent to treatment at this clinic as considered necessary and proper in diagnosing or treating my/his/her (minor or legal guardianship) of physical condition.

I have been given the Notice of Patients' Rights (Privacy Notice) and I consent to physical therapy treatment.

Signature: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

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Name: _____ Age: _____ Date of Birth: _____

Phone: _____

Referred by: _____

PCP (Primary Care Physician) if different than above: _____

Are you?: ☐ Right Handed or ☐ Left Handed

Prescription Medications: _____
(if you do not know the medication's name, list the condition the medication is used for)

Surgical History: _____

Have you received physical therapy treatment this calendar year?: ☐ Yes ☐ No

Medical History: (check all that you have ever had):

- ☐ Arthritis
- ☐ Broken Bones/Fractures
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Lung Problems
- ☐ Osteoporosis
- ☐ Seizure
- ☐ Stroke
- ☐ Head Injury
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Parkinson's Disease
- ☐ Other: _____

Are you having any of these symptoms? (check all that apply)

- ☐ Chest Pains
- ☐ Coordination Problems
- ☐ Numbness and/or Tingling
- ☐ Headaches
- ☐ Loss of Balance
- ☐ Pain at night
- ☐ Visual Problems
- ☐ Weakness

Are you pregnant? ☐ Yes ☐ No

History of current problems:

What is your Condition/Injury? _____
When did the problem(s) begin? _____
What Happened? _____
Have you had the problems(s) before? ☐ Yes ☐ No
What makes the problem(s) worse? _____
What makes the problem(s) better? _____

Current Limitations (check all that apply):

- ☐ Difficulty with walking
- ☐ Difficulty with stairs
- ☐ Difficulty with walking on rough ground
- ☐ Difficulty with bathing, dressing, eating
- ☐ Difficulty with chores, shopping, driving
- ☐ Difficulty with work, school
- ☐ Difficulty with recreational activities
- ☐ Difficulty Sleeping

I will advise the therapist if there are any changes in my physical condition that would alter my response to any of the questions on this form and in turn alter my treatment options.

Patient Signature: _____ **Date:** _____