ARLINGTON PAIN & THERAPY

PHYSICAL THERAPY & REHABILITAION

Welcome!

Patient Information:

Date:_____ Date Of Injury:_____ Date Of Surgery:_____
Name:_____ Date Of Birth:_____
SS#:_____ Age:_____ Marital Status: S M D W Male Female
Address:_____
City:_____ State:_____ Zip Code:_____
Home #:_____ Cell #:_____
Emergency Contact:_____ Phone #:_____
Employer:_____ Occupation:_____
Work #:_____ Referred By:_____

Insurance Information:

Primary Insurance Co:_____
Member ID:_____ Group #:_____
Claim#:_____ Adjustor:_____ Phone#:_____
Policy Holder:_____ SS#:_____ Date Of Birth:_____

Secondary Insurance Co:_____
Member ID:_____ Group #:_____
Claim#:_____ Adjustor:_____ Phone#:_____
Policy Holder:_____ SS#:_____ Date Of Birth:_____

Attorney:_____ Contact:_____ Phone#:_____

I hereby instruct and direct my health insurance company, personal injury protection insurance company, and/or my attorney to pay by check made out and mailed to Arlington Pain & Therapy for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered by this office. I agree to be financially responsible for all charges incurred at this office including my insurance deductible, co-payment, and services rejected by my insurance company, workers compensation insurance, and/or my attorney.

Signature_____ Date:_____

2001 S. E. Green Oaks Blvd #130
Tel: (817) 419-6111 Fax: (817) 419-9582

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Notice & Acknowledgement

I acknowledge that I have received the attached Notice of Privacy Practices:

_____ _____

Patient Or Personal Representative Signature Date

_____

Print Name

Authorization Of Release Of Protected Health Information To Family Members

I authorize Arlington Pain & Therapy to release protected health information to my family member(s) listed below:

Name:	**Relationship:**	**Phone#:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Office Policies

- A $35.00 fee will be assessed for returned checks.
- If copies of your medical records are needed, the first copy will be free and additional copies after that will have a fee.
- We require 24-hour notification if you are unable to come for any type of office visit or procedure.

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Medical History Form

Name _____ DOB _____ Age _____ Male/Female

Medications Currently Taking (Please include all prescriptions, over-the-counter, vitamins, and supplements)

NAME OF MEDICATION	DOSAGE OF MEDICATION

ALLERGIES to any medications, x-ray dyes or other substances Yes No
(If yes, please list name of medication and type of reaction.)

_____

_____

_____

_____

SURGERIES/HOSPITILIZATIONS

DATE	DETAILS

SEVERE INJURIES

DATE	DETAILS

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Name: _____

Instructions: Please rate the level of difficulty you have for each activity listed below according to the following scale.

Able to do without difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1	2	3	4	5	0

Activity	Date:	Date:	Date:	Date:
1. Lying flat				
2. Rolling over				
3. Moving-lying to sitting				
4. Sitting				
5. Squatting				
6. Bending/stooping				
7. Balancing				
8. Kneeling				
9. Standing				
10. Walking short distance				
11. Walking long distance				
12. Walking outdoors				
13. Climbing stairs				
14. Hopping				
15. jumping				
16. Running				
17. Pushing				
18. Pulling				
19. Reaching				
20. Grasping				
21. Lifting				
22. Carrying				

From the following list above, choose the 3 activities you would most like to be able to do without any difficulty.

1. _____

2. _____

3. _____

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