Performance Lifestyles, Inc. **Date of referral ______________**

Appt Date__________ Time____________

1. Patient Information

Name: Last______________________ First______________________ M.I.____
Gender M / F **Date of Birth_______________________**
Home Phone ______________________Work Phone_______________________
Cell Phone __________________________ Fax ____________________________
Email ____
Street Address____
City_____________________ State ______ Zip___________________________
Occupation____
Employer_________________________ Address____________________________
Emergency Contact__________________________ Relationship________________
Day Phone_________________________ Evening Phone_______________________
Diagnosis______________________________ Date of Onset/Symptoms________
Referring Physician_______________________NPI(office use)_________________
Address______________________________Phone____________Fax____________
Primary Care Physician___________________NPI(office use)_________________
Address______________________________Phone____________Fax____________
Have you received physical therapy for any diagnosis this year? Yes / No
Please let us know how you heard of us ____________________________________

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2. Insurance Information
*You do not need to complete this section if we have made a copy of your ins. card.

Primary Insurance________________________ Policy Number________________
Group #_________________Address___________________________Zip______
Copay/ Deductible______________Visits/yr______________Auth Req.__________
Secondary Insurance______________________ Subscriber___________________
Policy Number___________________________ Group Number________________

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3. Injury Information
*Complete this section only if your injury is work or auto related

Type of Injury: Auto / Workman's Compensation Date of Injury_________
Insurance Company_____________________ Claim Number___________________
Street Address____
City_____________________ State_________ Zip____________________________
Adjuster Name____________________________ Phone Number_________________

Attorney _________________________________ Phone ________________________

Medical History Questionnaire

Name______________________________ Date of Birth__________________________

Allergies____

1. What is your reason for seeking Therapy today?
   ____
   ____
2. List all medications you are currently taking.
   ____
   ____
3. Do you currently use shoe inserts or orthotics?
   ____
4. List past surgeries relevant to the current problem and any hospitalizations in the past year.
   ____
   ____
5. Any other Treatments for the current problem? If yes, what were they?
   ____
   ____
6. Do you have any other diagnoses or problems that may inhibit or prevent you from participating fully in a rehab program, including exercise?
   ____
   ____
7. What are your goals to achieve with Performance Lifestyles?
   ____
   ____

Some illnesses and conditions are genetically transferred. It is useful for us to know what conditions you or your family members have or have had in the past. Please tell us:

Condition	*I Had*	*When*	*Family (Specify)*	*When*
Arthritis	____	____	___ _________	____
Rheumatism	____	____	___ _________	____
Back Problems	____	____	___ _________	____
Neck Problems	____	____	___ _________	____
Sprain/ Strain	____	____	___ _________	____
Headaches	____	____	___ _________	____
Hand Problem	____	____	___ _________	____
Knee Pain	____	____	___ _________	____
Hip Pain	____	____	___ _________	____
Ankle Pain	____	____	___ _________	____

Performance Lifestyles, Inc.

Authorization and Assignment

1. I acknowledge receipt of Performance Lifestyles' privacy policies regarding private health information and disclosures (Posted at Front Desk).

2. I understand that I am financially responsible for charges not covered by my insurance carrier, including non-covered services, co-payments, co-insurance, and deductibles.

3. I hereby assign Performance Lifestyles, Inc. all payments for medical services rendered to myself or my dependents.

4. I acknowledge that I am responsible for keeping treatment authorizations updated including a) Insurance referrals for HMO plans, and/ or b) New doctor's orders every 30 days for Medicare patients.

5. If this injury is work related or a result of an automobile accident, you must have an active claim on file with your insurance carrier. The insurance carrier will be billed directly for all treatments rendered. If you would like a copy of your record sent to your attorney, we will need a signed release with his/ her name and address.

6. I authorize email communications regarding my care at Performance Lifestyles, Inc. including photographs.

Consent for Care and Treatment

I, the undersigned, do hereby give my consent for Performance Lifestyles, Inc. to furnish physical therapy care and treatment to (name) ______________________________, which is considered necessary and proper in diagnosing and treating their physical impairments.

I have read, understand and agree to the assignments above.

If you are under age 18, a parent or guardian must sign for you.

Signature of Patient/ Guardian ___________________________ Date __________

Name of Guardian ____________________________ Relationship _____________