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_____
Address_____
Phone_____ Fax_____
Primary Care Physician_____
NPI_____
Address_____
Phone_____ Fax_____

Have you received physical therapy for any diagnosis this year? Yes / No
Please let us know how you heard of us
_____

2. Insurance Information

*You do not need to complete this section if we have made a copy of your insurance card(s).

Subscriber_____

Primary Insurance_____ Subscriber
D.O.B_____
Policy Number_____ Group
Number_____
Address_____ City_____ State_____
Zip_____
Relationship to patient_____
Secondary Insurance_____
Subscriber_____
Policy Number_____ Group
Number_____

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. What supplements/vitamins do you take?
   _____
   _____
   _____. Would you be interested in getting assistance with this? Y / N
4. Do you currently use shoe inserts or orthotics?
   _____
   _____
5. List past surgeries relevant to the current problem and any hospitalizations in the past year.
   _____
   _____
   _____
6. Any other Treatments for the current problem? If yes, what were they?
   _____
   _____
   _____
7. Do you have any other diagnoses or problems that may inhibit or prevent you from participating fully in a rehab program, including exercise?
   _____

_____
_____

8. 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	____	____	___ _____	____

Authorization and Assignment

1. I acknowledge receipt of Performance Lifestyles' privacy policies regarding private health information and disclosures.

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 _____