

Date: _____

The Cantrell Center for Physical Therapy & Sports Medicine, P.C.

Patient Information

Name: _____ Age: _____ Date of Birth: ____/____/____
(First, MI, Last)

Address: _____
Street & Number City State Zip

Email Address: _____

Telephone#: (____) _____ Mobile Phone #:(____) _____

Sex: _____ Occupation: _____ SSN#: _____ D/L#: _____ State _____

Your Employer: _____ Work Phone#: _____

Address: _____
City State Zip

Spouse/Guardian Information

Spouse /Guardian Name: _____ SSN#: _____
First MI Last

Spouse's Employer Name: _____ Spouse Phone#:(____) _____

Spouse Occupation: _____ Spouse Date of Birth: _____

Emergency Contact: _____ Phone Number: (____) _____

Patient Medical History

PLEASE CHECK ALL THAT APPLY:

SMOKE DRINK DRUGS EXPOSED TO HIV PREGNANT - IF SO, HOW LONG? _____

ARTHRITIS		HIGH BLOOD PRESSURE
DENTURES		DIABETES
EPILEPSY		FRACTURES
ALLERGIES		HEART PACE MAKER
SWELLING		MIGRAINES
AIDS		INFECTIOUS HEPATITIS
CANCER		SHORTNESS OF BREATH
METAL INPLANTS		TUMOR
HEART PROBLEM		EXCESSIVE BLEEDER
INCONTINENCE		PELVIC PAIN
OTHER:		

YEAR	LIST SURGERIES AND YEAR: SURGERY
_____	_____
_____	_____
_____	_____
_____	_____

Injury Date or Date pain began: _____

No Accident

Where did Injury Occur?

Home Work Auto Accident
Other _____

Describe Symptoms/Pain/Injury you are being treated for today. _____

How Did You Hear About Our Office?

Patient: _____

- ___ Former Patient: Who? _____
- ___ You are a returning patient. Last seen here. _____
- ___ Yellow Pages. Which directory? _____
- ___ Your Employer: Who? _____
- ___ Insurance Benefit Plan: Plan Name: _____
- ___ Friend/Family: Who? _____
- ___ Other: _____

Acct.#: _____

Friends of The Cantrell Center are very special to us. Did anyone “*other than*” your physician recommend you to The Cantrell Center? We would like to thank them.

Name: _____

Address: _____

Marital Status


- M**
- S**
- D**
- W**

Employment Status

- Employed Full-time
- Employed part-time
- Unemployed
- Student Full-time
- Student Part-time
- Retired

Referring Physician: _____ Date of Next Doctor’s Appointment: _____

If you were referred to us by a doctor other than your primary care physician: Who is your family physician so that we may forward your progress reports to him/her? _____

Have you been treated by another: (**Please CIRCLE all that apply**) physical therapist, chiropractor, or Home Healthcare agency since January 1st of this year? No _____ Yes _____ **If yes,**  **Have you been**

discharged from their facility? No _____ Yes _____ If yes, Date last seen _____

Please call our office at (478) 953-3535 to see what your cost will be for outpatient physical therapy.

Please fill out the following information for each that applies:

Physical Therapy Office _____ Phone #: _____

Chiropractor’s Office _____ Phone #: _____

Home Health Care Agency _____ Phone #: _____

Date you were discharged from Home Health Care? _____

Have you had X-rays/MRI? When? _____ Where? _____

My insurance benefits have been verified and explained to me prior to my first visit. \$ _____ Deductible _____ % or _____ co-pay/ **I understand and agree my co-pay is required each visit and/or co-insurance payment is required a minimum of once per week.** _____ (please initial)

I have received and understand The Cantrell Center’s Notice of Information Practices. I hereby consent to the use and disclosure of my personal health information for purposes as noted in The Cantrell Center’s Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. _____ (please initial)