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

## Patient Information

**Date:_____**

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

Address:_____
Street & Number City State Zip
Mailing Address if different: _____
Home Phone#:(____)_____ Cell Phone #:(____)_____Work Phone#: (____)_____x:____
May we (circle one): Text / Email you an appointment reminder?
Cell phone carrier (circle one): Verizon, Sprint, AT&T, T-Mobile, Other:_____

Sex:____ SSN#:_____ Email Address: _____
Occupation: _____ Your Employer: _____
Address:_____
City State Zip

**Marital Status**
M S D W
❑ ❑ ❑ ❑

**Employment Status**
❑ **Employed Full-time** ❑ **Employed part-time** ❑ **Unemployed**
❑ **Student Full-time** ❑ **Student Part-time** ❑ **Retired**

## Spouse/Guardian Information

Spouse/ Parent/Guardian Name: _____SSN#:_____
First MI Last
Relationship: _____ Mobile Phone #:(____)_____
Date of Birth:___/___/___ Employer Name:_____ Work Phone #:(____)_____

Spouse/ Parent/Guardian Name: _____SSN#:_____
First MI Last
Relationship: _____ Mobile Phone #:(____)_____
Date of Birth:___/___/___ Employer Name:_____ Work Phone #:(____)_____

**Emergency Contact:_____ Phone Number: (___)_____**
Relationship: _____

**Patient Medical History: (PLEASE CHECK ALL THAT APPLY)**
☐**SMOKE** ☐**DRINK** ☐**DRUGS** ☐**EXPOSED TO HIV** ☐**PREGNANT – IF SO, HOW LONG?**_____

| | | | |
|---|---|---|---|
| Arthritis - Osteo | | High Blood Pressure | |
| Arthritis - Rheumatoid | | Diabetes | |
| Dentures | | Fractures | |
| Epilepsy | | Heart Pacemaker | |
| Allergies | | Migraines | |
| Do you carry Epipen? | | Liver Disease | |
| Swelling | | Shortness of Breath | |
| HIV/Aids | | Tumor | |
| Cancer | | Excessive Bleeding | |
| Metal Implant | | Pelvic Pain | |
| Heart Problems | | Asthma | |
| Incontinence | | Other: | |
| Osteoporosis | | | |

**LIST SURGERIES AND YEAR:**

| YEAR | SURGERY |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Injury Date or Date pain began: _____

❑ **No Accident**

If Injury - Where did Injury Occur?
❑Home ❑Work ❑Auto Accident- What State?_____
❑Other_____

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

Patient:_____ Acct.#:_____

**How Did You Hear About Our Office?**

___ 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: _____

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:_____

**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?_____
Telephone #_____

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 _____ Date last seen/treated _____**
**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. Note: this is an **"estimate"** and **not a guarantee of benefits** as described by your insurance carrier: $_____ 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)