Name: ______________________ Nickname: ______________

Date of Birth: ____/____/______ Age: ______ Sex: Male / Female

Address: ______________________________

Mailing Address (if different from previous): ______________________________

City: ______________ State: __________ Postal Code: ______________

Home Phone: (____) _____-______ Cell Phone: (____) _____-______

Email Address: ______________@______________.com

Which would you prefer to be contacted by: ☐ Text ☐ E-mail ☐ Phone Call

Emergency Contact: ______________ Relationship to Patient: ______________

Phone Number (____) _____-______

Marital Status: ☐ Single ☐ Married ☐ Other
If married, what is the name of your spouse? ______________________________

Referring Physician: ______________ Follow-up appt. with doctor: ____/____/____

Primary Care Physician (if different from referring MD): ______________________________

Insurance Information

Primary Insurance Company: ______________________________

Name of Insured: ______________ Date of Birth: ____/____/______ Sex: Male / Female

Relationship to Patient: ______________ Phone Number: (____) _____-______

Address: ______________ City: __________ State: ______ Zip: ______

Secondary Insurance Company: ______________________________

Name of Insured: ______________ Date of Birth: ____/____/______ Sex: Male / Female

Relationship to Patient: ______________ Phone Number: (____) _____-______

Address: ______________ City: __________ State: ______ Zip: ______

**** ATTENTION MEDICARE PATIENTS ****

1.) Are you currently receiving Home Health Care Services? ☐ Yes ☐ No

2.) Have you received Home Health Care Services in the past year? ☐ Yes ☐ No

****If yes**, please provide the following:

Name of Home Health Agency: ______________ Phone Number: (____) _____-______

***NOTE:** If AT ANY time during the course of your treatments here at Shull Physical Therapy Center you sign up for or begin Home Health Care, WE MUST BE NOTIFIED. All charges incurred during the period that you are receiving Home Health Care WILL BE YOUR RESPONSIBILITY.

I have read, I understand and I accept FULL FINANCIAL responsibility.

Signed: ______________________ Date: ______________

Shull Physical Therapy Center

4646 Corona Dr. Suite #130
Corpus Christi, Texas 784811

CONDITIONS OF ADMISSION

Release of Information: The agency may disclose all or any part of the patient's record to any person or corporation which is or may be liable under a contract to the agency or to a family member or employer of the patient for all or part of the agency's charge, including but not limited to, hospital or medical service companies, insurance companies, workmen's compensation carriers, welfare funds, or the patient's employer.

Consent for Treatment: The patient is under the control of his physician, and the undersigned consents to any treatment or procedures rendered the patient by the agency under the general and specific instructions of the physician. It is further understood that the agency is authorized to carry out all instructions of the patient's doctor and that the agency is hereby relieved of any and all liability occurring from the performance of the doctor's instructions.

I request and authorize the staff of Shull Physical Therapy Center to provide me with treatment, and to perform any procedures now contemplated or such additional procedures as my doctor may deem reasonable and necessary.

I authorize the Social Security Administration to disclose information regarding my Medicare coverage, including but not limited to, verification of my Medicare number, effective dates and type of coverage.

The undersigned certifies that he/she has read the foregoing and is the patient, or is duly authorized by the patient as patient's general agent to execute the above and accept its terms. It is further understood that this release remain remains in effect for (1) year unless otherwise revoked.

______________________________________ ______________, 20____

Patient's Signature Date

ASSIGNMENT OF BENEFITS

I authorize ____________________________ Insurance Company to pay directly to Shull Physical Therapy Center all benefits due me, if any, by reason of services described in the statements rendered, and as provided for in the above policy contract with above-mentioned insurance company. I understand that Shull Physical Therapy Center, which has accepted assignment, has the same right as I do to appeal carrier's determination.

__________ _____, 20___

Patient's Initials Date

FINANCIAL RESPONSIBILITY

I hereby accept all responsibility for treatment costs not covered or reimbursed by third-party payers. The undersigned certifies that he/she has been explained the treatment costs and is the responsible party and accepts these terms.

______________________________________ ___________, 20_____

Patient's Signature Date

S H U L L
Physical Therapy Center

Notice of Privacy Practices

This notice describes privacy practices on how your medical information may be disclosed, used, and your access to this information. Please review and sign this notice.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, and for administrative purposes. We may change our policies and this notice at any time. The revised policy will apply to all protected health information we maintain. A copy of our Privacy Practice is available to you upon request.

If, or when, we change our notice, we will have *the new* notice available in our office. A copy of *the new* notice will also be available to you upon request.

Please let us know if you would like a copy of the Privacy Practices.

I, ______________________________, have read and understand the above information.
Patient Name

______________________________ ____________________

Patient Signature Date

Shull Physical Therapy Center
Patient Medical/Health History

Certain procedures are contraindicated with different health issues. Please answer these questions to the best of your knowledge to ensure we provide you with the best plan of care.

GENERAL HEALTH STATUS

Please rate your health:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

SOCIAL/HEALTH HABITS

Do you have any customs, religious beliefs or wishes that might affect care? ______________

____

Are you currently employed? ☐ Yes ☐ No

If so, are you:

- ☐ Full time
- ☐ Part time

What is your occupation? ____________________

If not, are you:

- ☐ Retired
- ☐ Homemaker
- ☐ Student
- ☐ Disabled

Do you smoke? ☐ Yes ☐ No

If yes: ☐ Cigarettes
☐ Cigars
☐ Pipe

How many per day? (If cigarettes, how many packs per day?

____

If no, have you smoked in the past? ☐ Yes ☐ No

If yes, when did you quit? ______________

Do you drink alcohol? ☐ Yes ☐ No

If yes, how many drinks, on average, do you consume per week? ________________________

Do you exercise beyond normal daily activities? (i.e. walking program, go to the gym. etc.)

____

PATIENT HEALTH HISTORY

Please check all that apply to you:

- ☐ Heart Disease
- ☐ Congestive Heart Failure
- ☐ Hypertension
- ☐ Stroke
- ☐ Diabetes
- ☐ Cancer – Type of cancer (i.e. breast, cervical, prostate, etc.)
  ____
- ☐ Psychological
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Other: __________________________

LIVING ENVIRONMENT

Does your home have:

- ☐ Stairs:
  - ☐ With rails
  - ☐ Without rails
- ☐ Ramps
- ☐ Elevator
- ☐ Uneven terrain
- ☐ Assistive devices (i.e. bathroom railings, etc.)
  Please list: _____________________
  ____

Do you use one or more of the following:

- ☐ Cane
- ☐ Walker
- ☐ Manual wheelchair
- ☐ Motorized wheelchair
- ☐ Glasses
- ☐ Hearing aids

FUNCTIONAL STATUS/ACIVITY LEVEL

Check all that apply:

- ☐ Difficulty with self-care (bathing, dressing, etc.)
- ☐ Difficulty with community/work activities
- ☐ Difficulty with locomotion/movement:
  - ☐ Bed mobility
  - ☐ Transferring
  - ☐ Walking
  - ☐ On level surfaces
  - ☐ Uneven surfaces
  - ☐ On ramps
  - ☐ On stairs

MEDICAL/SURGICAL HISTORY

Have you ever had surgery? ☐ Yes ☐ No

If so, what type of surgery and when? (mm/yyyy)

______________________ Date: ______/________

______________________ Date: ______/________

______________________ Date: ______/________

______________________ Date: ______/________

______________________ Date: ______/________

______________________ Date: ______/________

______________________ Date: ______/________

______________________ Date: ______/________

CURRENT CONDITIONS/COMPLAINTS

When did the problem begin? _______/__________

Have you had this problem before? ☐ Yes ☐ No

Did the problem get better? ☐ Yes ☐ No

How long did the problem last? ______________

Are you seeing someone else for this problem?

☐ Yes ☐ No

If so, who? ______________________________

Have you had physical therapy for this problem?

☐ Yes ☐ No

If so, how long were you receiving treatment?

____

How are you taking care of the problem?

____

What makes it better? ______________________

What makes it worse? ______________________

What are your goals for physical therapy? _______

____

____

OTHER CLINICAL TESTS

Within the past year, have you had any of the following tests? (Check all that apply)

- ☐ Angiogram
- ☐ Arthroscopy
- ☐ Biopsy
- ☐ Blood Tests
- ☐ Bone Scan
- ☐ Bronchoscope
- ☐ CT Scan
- ☐ Doppler Ultrasound
- ☐ ECG
- ☐ EEG
- ☐ EKG
- ☐ EMG
- ☐ Mammogram
- ☐ MRI
- ☐ Myelogram
- ☐ Nerve Conduction Velocity
- ☐ Pap Smear
- ☐ Pulmonary Functional Test
- ☐ Spinal Tap
- ☐ Stress Test
- ☐ X-Ray
- ☐ Other: ________________________

MEDICATIONS

Do you take any non-prescription medications? (Check all that apply)

- ☐ Advil/Aleve
- ☐ Antacids
- ☐ Ibuprofen
- ☐ Antihistamines
- ☐ Aspirin
- ☐ Decongestants
- ☐ Herbal Supplements
- ☐ Other: ________________________

Have you previously taken any medications for this condition? ☐ Yes ☐ No

If yes, please list: _______________________

____

Please list or attach a list of all prescription medications you are currently taking?

____

____

____