

# PHYSICAL THERAPY EVALUATION PATIENT HISTORY

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Physician: \_\_\_\_\_

Date of Next Appointment with Physician: \_\_\_\_\_

Injury /Illness Description and How it Began: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have you had this Injury/Illness Before? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you had any surgery related to this problem? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please give date and details: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Occupation: \_\_\_\_\_

Are you currently working? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, are you under any restrictions? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have you had other treatments for this problem?

Medications

Chiropractic Care

Physical Therapy

Injections

Home Exercises

Other: \_\_\_\_\_

If so, please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Special Tests/Results (X-ray, EMG, MRI, CT Scan, Blood Tests, etc.)

\_\_\_\_\_  
\_\_\_\_\_

What limitations do you now have due to this condition in your day to day activities, or occupational tasks?

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Please describe your personal goals in attending physical therapy: \_\_\_\_\_

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Please mark those that apply to your current or past medical history:

Yes	No	High Blood Pressure
Yes	No	Cardiac problems, including pacemakers
Yes	No	Respiratory conditions, allergies or asthma
Yes	No	Diabetes
Yes	No	Cancer, Malignancies or Tumors
Yes	No	Rheumatoid Arthritis
Yes	No	Osteoarthritis
Yes	No	Weight Loss or Gain
Yes	No	Bowel or Bladder Problems
Yes	No	Pregnant

Other: \_\_\_\_\_

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Please tell us how you heard about our facility \_\_\_\_\_

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**PLEASE CONTINUE TO NEXT PAGE**

**Mark Area of Involvement**

Time of day least pain: \_\_\_\_\_

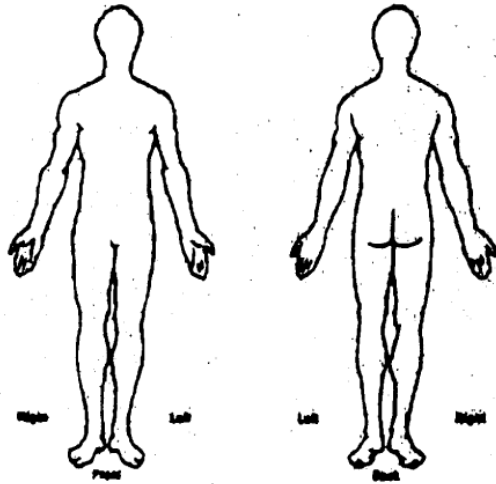
Time of day worst pain: \_\_\_\_\_

On a scale from 0 to 10, describe your pain over the past week.

Least Pain: 0 1 2 3 4 5 6 7 8 9 10

Worst Pain: 0 1 2 3 4 5 6 7 8 9 10

Pain Today: 0 1 2 3 4 5 6 7 8 9 10



# **GPT PATIENTS PLEASE READ OVER AND SIGN**

## **INSURANCE AND BILLING**

AS A CONVENIENCE TO YOU, GPT WILL BILL YOUR HEALTH INSURANCE COMPANY FOR YOUR PHYSICAL THERAPY OR OCCUPATIONAL THERAPY. PLEASE TAKE A MOMENT TO REVIEW YOUR POLICY. YOUR POLICY MAY ONLY PAY UP TO A CERTAIN DOLLAR AMOUNT OR PERCENTAGE. ALSO, YOUR POLICY MAY ONLY ALLOW A CERTAIN NUMBER OF VISITS AND MAY EVEN REQUIRE PRE-CERTIFICATION. EVERY POLICY IS DIFFERENT SO FOR YOUR BENEFIT, PLEASE TAKE THE TIME TO REVIEW YOURS. FOR OUR RECORDS, PLEASE KEEP US UPDATED ON ANY CHANGES SUCH AS YOUR BILLING ADDRESS, PHONE NUMBER OR INSURANCE COVERAGE.

(NOTE) ANY BILLING QUESTIONS MAY BE DIRECTED  
TO:

**BAILEYS PROFESSIONAL SERVICES.**

CONTACT SHELLY AT 302-687-1720

## ***CANCELLATION NOTICE***

HERE AT GILLETTE PHYSICAL THERAPY, OUR PRIORITY IS QUALITY PATIENT CARE. WE ARE VERY DEDICATED TO YOU THE CLIENT, AND WEARS VERY SERIOUS ABOUT RESULTS. IN ORDER FOR US TO BETTER ASSIST YOU IN MAXIMIZING YOUR DESIRED OUTCOMES, COMPLIANCE TO YOUR SCHEDULED CLINIC APPOINTMENT TIMES IS STRONGLY ENCOURAGED. OUR TIME IS ALSO VERY VALUABLE TO ASSISTING OTHER CLIENTS; FOR THESE REASONS A 24 HOUR NOTICE IS APPRECIATED. IF A 24 NOTICE OF CANCELLATION IS NOT RECEIVED, A \$25.00 FEE MAY BE CHARGED TO YOU.

THANK YOU,

**THE FRIENDLY STAFF AT Gillette Physical Therapy**

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## **WORKERS SAFETY & COMPENSATION**

IF YOU ARE AN INJURED WORKERS COMP PATIENT PLEASE BE AWARE OF THE FOLLOWING:

- WORKERS COMPENSATION FOLLOWS YOUR THERAPY
- YOUR THERAPY APPTS ARE IMPORTANT SO PLEASE KEEP CANCELLATIONS TO A MINIMUM.
- ALL CANCELLATIONS AND NO SHOWS ARE DOCUMENTED FOR WORKERS COMP.
- YOU WILL BE RESPONSIBLE FOR ANY BALANCE WORKERS COMPENSATION DOES NOT PAY.