

PORT CITY PHYSICAL THERAPY PATIENT DATA SHEET

First: MI: Last:

Date of Birth: Age: Gender: Male  Female

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physical Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

May we send you text messages relating to your care with us?  Yes  No

By providing your text number below, you understand that text messages will NOT be sent via secure, encrypted format.

OK To Call	OK To Text	Phone:	Best Time To Call
<input type="checkbox"/>	<input type="checkbox"/>	Home: _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Work: _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cell: _____	_____

SSN:

May we send you emails relating to your care with us?  Yes  No

By providing your email address below, you understand that emails will NOT be sent via secure, encrypted format.

Email: \_\_\_\_\_

Preferred language:

Intepreter required?  Yes

Married  Single  Divorced  Widowed  Separated  Unknown

Student Status:  Full-Time  Part-Time  None

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

Injury Area: \_\_\_\_\_

Auto or Work Accident: \_\_\_\_\_

## EMPLOYMENT STATUS

Employment Status:

 Active Military
  Full-Time
  None
  Part-Time
  Retired
  Self Employed

Employer:

Occupation:

Address:

Phone:

Employer:

Occupation:

Address:

Phone:

## INSURANCE INFORMATION

Primary Insurance

Policy Holder's Name:

Holder's Birth Date:

Policy or Certificate #:

Group #:

Policy Holder's Employer:

Secondary Insurance:

Policy Holder's Name:

Holder's Birth Date:

Policy or Certificate #:

Group #:

Policy Holder's Employer:

 Are you receiving or have you received Home Health Services?  Yes  No

 Are you receiving or have you received other therapy services?  Yes  No

How did you hear about us?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Physician      | <input type="checkbox"/> Hospital               | <input type="checkbox"/> Marketing Ad - Print               |
| <input type="checkbox"/> Employer       | <input type="checkbox"/> Cross Referral         | <input type="checkbox"/> Marketing Ad - TV                  |
| <input type="checkbox"/> Case Manager   | <input type="checkbox"/> Friend - Word of Mouth | <input type="checkbox"/> Marketing Ad - Billboard           |
| <input type="checkbox"/> Former Patient | <input type="checkbox"/> Attorney               | <input type="checkbox"/> Marketing Ad - Direct Mail - Email |
| <input type="checkbox"/> Adjustor       | <input type="checkbox"/> Self                   | <input type="checkbox"/> Marketing Ad - Facebook            |
| <input type="checkbox"/> School         | <input type="checkbox"/> Screens - Open Houses  | <input type="checkbox"/> Marketing Ad - Other               |

Specify if other : \_\_\_\_\_

Note: Please provide us with the most updated information down below.

CONTACTS

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DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date



PORT CITY PHYSICAL THERAPY MEDICAL HISTORY FORM

PATIENT NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

REFERRING PHYSICIAN'S NAME: \_\_\_\_\_ DATE OF INJURY OR ONSET: \_\_\_\_\_

CAUSE OF INJURY OR ONSET: \_\_\_\_\_ ARE YOU PRESENTLY WORKING? Y N

PRIMARY CARE PHYSICIAN'S NAME: \_\_\_\_\_ DATE OF NEXT MD APPT: \_\_\_\_\_

WHAT IS YOUR REASON FOR ATTENDING THERAPY: \_\_\_\_\_

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

- 1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

- 1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR
DO YOU USE TOBACCO? (circle one) YES NO IF YES, HOW MUCH? \_\_\_\_\_

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO IF YES, WHEN \_\_\_\_\_ AND WHY \_\_\_\_\_

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one) YES NO
WHAT WAS DONE / WHAT WERE THE RESULTS: \_\_\_\_\_

HAVE YOU HAD PRIOR PHYSICAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO
WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH
FOR HOW LONG? \_\_\_\_\_

CURRENT MEDICATIONS: \_\_\_\_\_

ALLERGIES: Medication \_\_\_\_\_ Reaction \_\_\_\_\_ Medication \_\_\_\_\_ Reaction \_\_\_\_\_

ARE YOU ALLERGIC TO LATEX? (circle one) YES NO If yes what is the Reaction \_\_\_\_\_
Are you Allergic to Dexamethasone? YES NO If yes what is the Reaction \_\_\_\_\_

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

- ANEMIA, ARTHRITIS, CANCER, CARDIOVASCULAR PROBLEMS, HOLTER MONITOR, PACEMAKER, HIGH BLOOD PRESSURE, LOW BLOOD PRESSURE, CURRENTLY PREGNANT, DIABETES, DEPRESSION, DIZZINESS/FAINTING, FRACTURES, HEADACHES, HEPATITIS/HIV, KIDNEY PROBLEMS, MRSA, OSTEOPOROSIS, RESPIRATORY PROBLEMS, ASTHMA, COPD, SEIZURES, THYROID PROBLEMS

If checked any above, explain: \_\_\_\_\_

ANY OTHER MEDICAL PROBLEMS: \_\_\_\_\_

SIGNATURE OF PATIENT: \_\_\_\_\_ REVIEWED BY Therapist: \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT TO USE OF LIKENESS AND  
TESTIMONIAL AND RELEASE**

I, \_\_\_\_\_, hereby consent to allow Port City Physical Therapy and its employees, agents, partners, and affiliates (collectively “Clinic”), to use my name, photograph, videotape/audiotape recording, and/or written testimonial (“marketing materials”) in Clinic’s marketing brochures, publications, and/or on their website and social media accounts, including but not limited to Facebook and Twitter, to promote the services offered by Clinic. I understand and agree that these marketing materials are owned by Clinic and will not be returned to me.

I hereby release, hold harmless, and forever discharge the Clinic from any and all claims, demands, and causes of action which I have or may have by reason of this authorization.

Further, I hereby affirm that I have read this Consent to Likeness and Release, and I fully understand the content, meaning, and impact of this agreement. This agreement shall be binding upon me and my heirs, legal representatives and assigns.

\_\_\_\_\_  
Participant Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian (If Participant is a Minor)

**HIPAA AUTHORIZATION FOR DISCLOSURE OF PHI**

I, \_\_\_\_\_, hereby consent and authorize Port City Physical Therapy and its employees, agents, partners, and affiliates (collectively “Clinic”) to disclose my Protected Health Information (“PHI”), as that term is defined in the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), for marketing purposes, as stated below. I understand that subsequent disclosures by recipients of my PHI may not be protected by the HIPAA Privacy Rule or other applicable medical record privacy laws.

Further, I authorize Clinic to disclose my PHI, in the form of written statements, photographs, and videotape/audiotape recordings, for purposes of promoting and advertising Clinic’s services.

I understand that I may revoke this authorization at any time by giving written notice to Clinic, except to the extent that Clinic and its agents, employees, and representatives may have taken action in reliance on this authorization.

This authorization is effective on the date stated below for an indefinite period of time. A photocopy of this authorization form is valid and should be given the same force and effect as the original.

\_\_\_\_\_  
Participant Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian (If Participant is a Minor)