



**PATIENT INFORMATION** **EMAIL ADDRESS:** \_\_\_\_\_

First Name:	Last Name:	Middle Initial:	Date: / /
Address:		City:	State: Zip:
Birth date: / /	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -		Spouse:
Chose Clinic Because/ Referred to Clinic By <input type="checkbox"/> Dr.: <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Family <input type="checkbox"/> Friend			
<input type="checkbox"/> Former Patient <input type="checkbox"/> Close to Work/Home <input type="checkbox"/> Website <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Street Sign <input type="checkbox"/> Other:			

**WORK INFORMATION**

Employer:	Work Phone ( ) -	Ext.
Occupation:	Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed	

**CARE PROVIDER INFORMATION**

Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -

**INSURANCE INFORMATION ( PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST )**

Primary Insurance Name:	
Subscriber's Name (If different):	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:	
Name of Secondary Insurance:	
Subscriber's Name:	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:	

**AUTO OR WORK INJURY CLAIM ( PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP )**

Insurance Name: <input type="checkbox"/> Auto :	<input type="checkbox"/> Labor & Industries:
Adjuster/Claim Manager:	Phone: Ext.:
Address:	City: State: Zip:
Claim #:	Accident Date: / / Cause:

**ATTORNEY INFORMATION**

Name:	Law Firm:	Phone: ( ) -
Address	City	State: Zip:

**IN CASE OF EMERGENCY**

Name of Local Friend or Relative (Not Living at Same Address):		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

I authorize my insurance benefits be paid directly to Searcy Physical Therapy. I understand that I am financially responsible for any balance. I also authorize Searcy Physical Therapy to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



**PAST MEDICAL HISTORY FORM**

**Patient Name** \_\_\_\_\_

BLOOD PRESSURE		YES	NO	JOINT CONDITIONS		YES	NO
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Normal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremity Dislocation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE		YES	NO	OTHER CONDITIONS		YES	NO
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerotic Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MUSCLE CONDITION		YES	NO	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carpal Tunnel R/L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tennis Elbow R/L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Eyesight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back/Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limited Limb Movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Other: _____			
				_____			
				_____			
				_____			
LUNGS		YES	NO				
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

WORK ACTIVITY	STRESS LEVEL	HABITS	
<input type="checkbox"/> Sitting	<input type="checkbox"/> Low	<input type="checkbox"/> Smoking	Packs a Day _____
<input type="checkbox"/> Standing	<input type="checkbox"/> Medium	<input type="checkbox"/> Alcohol	Drinks a Week _____
<input type="checkbox"/> Light Labor	<input type="checkbox"/> High	<input type="checkbox"/> Coffee/Soda	Cups a Week _____
<input type="checkbox"/> Heavy Labor			

What types of exercise do you perform? : \_\_\_\_\_

What things cause stress in your life? : \_\_\_\_\_

Are you taking any seizure medication?  YES  NO If yes list name: \_\_\_\_\_

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?  
 YES  NO If yes list name: \_\_\_\_\_

List all medications you are currently taking: \_\_\_\_\_

List all surgeries in the past two years (Including dates): \_\_\_\_\_

Are you pregnant?  YES  NO What week?: \_\_\_\_\_

Have you had any injuries related to work?  YES  NO If yes list body part and date.: \_\_\_\_\_

Have you had any Auto Accidents  YES  NO If yes list body part and date.: \_\_\_\_\_

Have you had Physical Therapy or Massage Therapy before?  YES  NO Where: \_\_\_\_\_

Signature of Patient, Parent, Guardian, Personal Representative

Date



**Searcy Physical Therapy**

**CONSENT FOR PURPOSES OF TREATMENT  
PAYMENT, AND HEALTH CARE OPERATIONS**

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I consent to the use of disclosure of my Protected Health Information (PHI) by Searcy Physical Therapy for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Searcy/Beebe Physical Therapy. I understand that diagnosis or treatment of me by Searcy/Beebe Physical Therapy may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my PHI information is used or disclosed to carry out treatment, payment, or health care operations of this practice.

Searcy/Beebe Physical Therapy is not required to agree to the restrictions that I may request. However, if Searcy/Beebe Physical Therapy agrees to a restriction that I request, the restriction is binding on Searcy/Beebe Physical Therapy.

I have the right to revoke this consent, in writing, at any time, except to the extent that Searcy/Beebe Physical Therapy has taken action in reliance on this consent.

My PHI means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This PHI relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have a right to review Searcy/Beebe Physical Therapy's Notice of Privacy Practices (NPP) prior to signing this document. The NPP describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my therapy services, or in the performance of health care operations of Searcy/Beebe Physical Therapy. The NPP of Searcy Physical Therapy is also provided at 2921 Hawkins Drive, AR 72143/710 Suite D Dewitt Henry Drive, Beebe AR 72012. This NPP also described my right and Searcy/Beebe Physical Therapy's duties with respect to my protected health information.

Searcy/Beebe Physical Therapy reserves the right to change the privacy practices that are described in the NPP. I may obtain a revised NPP by calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Personal Representative's Authority

**SEARCY/BEEBE PHYSICAL THERAPY  
ADDENDUM: PATIENT PRIVACY**

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

In an effort to comply with current **HIPPA** (Health Insurance Portability Accountability Act) regulations, we need you to complete the following information. Please list any person other than your doctor with whom we may discuss your private health information or financial matters:

\_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

In the event that we are unable to reach you personally, do you give your permission to a staff member of Searcy/Beebe Physical Therapy to leave a message on your answering machine, voice mail, and/or with someone at your home number or cell number concerning your private health information or financial matters? (Please check yes or no)

**YES** \_\_\_\_\_ **NO** \_\_\_\_\_

I understand I can withdraw the above at any time, with written request. I also understand that it is my responsibility to ensure that my family member or significant other do not divulge or use the information in any way without discussing with me first.

\_\_\_\_\_  
Patient or legally authorized individual signature \_\_\_\_\_ Date

\_\_\_\_\_  
Relationship to patient if signed by anyone other than the patient such as (parent, legal guardian, personal representative, etc.)