UNIVERSAL PHYSICAL THERAPY
23 Main Street
Newport, NH 03773
603-863-3260

PATIENT INFORMATION
(please complete each section)

NAME: _____ DATE: _____
MAILING ADDRESS: _____TOWN: _____ STATE: _____ZIP: _____
PHYSICAL ADDRESS: _____TOWN: _____STATE: ____ ZIP: _____
HOME PH #: _____ CELL #: _____ SS#: _____
DATE OF BIRTH: _____ AGE: _____ MARITAL STATUS: _____ RACE: _____
EMAIL ADDRESS: _____ SEX: MALE/FEMALE__

___WORK FULL TIME ___WORK PART TIME ___STUDENT ___ RETIRED
___HOMEMAKER ___UNEMPLOYED ___DISABLED
PATIENT'S EMPLOYER: _____WORK#_____
ADDRESS:_____

NAME OF SPOUSE/PARENT OR GUARDIAN: _____
HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____
EMERGENCY CONTACT: _____PHONE:_____

REFERRING PHYSICIAN: _____PRIMARY PHYSICIAN: _____
REASON FOR VISIT:_____
DATE OF INJURY (or ONSET)_____ SURGERY DATE:_____
GOAL: _____ NEXT DR APPT ____/_____/____

ON A SCALE 0-10, ZERO BEING NO PAIN,
HOW IS YOUR PAIN AT ITS WORST?_____.. AT ITS BEST_____
RELATED CAUSES: Auto Accident ___ Fall___ Abuse___ Sports Injury ___
Employment injury ___ Surgery ___ Other Accident ___ None of them ___

Are you currently receiving or have received any of the following in the last 12 months?
___ Physical Therapy ___Speech Therapy ___Occupational Therapy ___VNA __ None

INSURANCE INFORMATION (please complete at least one of the follow sections)

PRIMARY INSURANCE: _____ Subscriber:_____
Subscriber's Employer_____ Subscriber's D.O.B._____
Subscriber's ID#_____

SECONDARY INSURANCE_____ Subscriber: _____
Subscriber's Employer_____ Subscriber's D.O.B. _____
ID# _____

WORKER'S COMP INSURANCE:
Insurance Name: _____ Ins Phone# #: _____
Address: _____
Employer: _____ Work Phone # _____
Address: _____
Case Manager: _____ Phone #:_____Fax#: _____
Claim #:_____

AUTO INSURANCE or ATTORNEY INFORMATION:
Name: _____ Phone # _____
Address: _____

MEDICAL HISTORY

Have you EVER been diagnosed as having any of the following conditions? (Circle answer)

Cancer	Yes	No	Depression	Yes	No
Heart Problems	Yes	No	Hepatitis	Yes	No
High Blood Pressure	Yes	No	Tuberculosis	Yes	No
Circulation Problems	Yes	No	Stroke	Yes	No
Asthma	Yes	No	Kidney Disease	Yes	No
Emphysema / Bronchitis	Yes	No	Anemia	Yes	No
Chemical Dependence	Yes	No	Epilepsy	Yes	No
Thyroid Problem	Yes	No	Vision Impairment	Yes	No
Diabetes	Yes	No	Hearing Impairment	Yes	No
Multiple Sclerosis	Yes	No	Other _____		
Rheumatoid Arthritis	Yes	No			
Other Arthritic Condition	Yes	No			

Have you had any major life changes in the past year? (divorce, death, etc) Yes No

During the past month have you been feeling down or hopeless? Yes No

Do you ever feel unsafe at home or has anyone injured or tried to injure you? Yes No

Do you smoke?	Yes	No	
Did you smoke in the past?	Yes	Date Quit_____	No
Do you consume alcohol?	Yes	Average amount _____	No
Do you exercise regularly?	Yes	(frequency/Duration) _____	No

Have you recently experienced any of the following? (Circle answer)

Weight loss or gain:	Yes	No	Fatigue:	Yes	No
Nausea or Vomiting:	Yes	No	Weakness:	Yes	No
Fever / Chills / Sweats:	Yes	No	Numbness / Tingling:	Yes	No

Are you currently or could you possibly be pregnant? Yes or No

Please list any **over-the-counter** medications you have taken in the past week: _____
_____

Please list any **prescription medications** and the **dosage** you are currently taking or provide a list to copy:
(Pills, Injections, patches, etc.) _____
_____
_____
_____

List any allergies to medications or pertinent allergies:
_____

Are you sensitive to **latex** Yes No
Are you sensitive to **adhesives** (such as bandages or tape)? Yes No

- I hereby allow Universal Physical Therapy to provide care for myself / minor child. Appropriate care including but not limited to use of tape, modalities, hands on skill and exercise.

- Our billing company is RevFlow. You will receive bills from them on our behalf. Questions on billing can be answered by them or here at the clinic.

- We require you to pay your copayment at the time of service unless other arrangements have been made.

- If your insurance has changed or is expected to change while you are having care at Universal Physical Therapy, you must provide us with that information immediately to avoid a lapse in authorization of physical therapy coverage. If this occurs, your insurance company may not pay for services and you WILL BE responsible for the unpaid balance.

- If your care is being billed to a worker's compensation carrier and your claim is denied, you will be responsible for payment of the bill at that time. We will make all attempts to bill your health insurance. You will be responsible for the bill once it is denied.

- If you were involved in an accident which you are depending on a settlement to pay your medical bills, you will need to provide us with an alternate form of payment. Example: Credit card, personal health insurance, health savings or reimbursement account, etc. We do not bill car insurance, lawyers or wait for settlements to be reached for bill to be covered.

- In the case of a minor, the parent or guardian who signs below is responsible for any outstanding balance.

- **Cancellations or no shows without 24 hours' notice will be charged a fee of $50. This fee will be directly charged to you, not your insurance company.**

- Also, by signing below, you are authorizing insurance payment to be made directly to Universal Physical Therapy. If you should receive an insurance check for services rendered by Universal Physical Therapy, we ask that you mail or bring in the payment as soon as possible. Thank you for your cooperation.

Patient's Signature_____Driver's License_____

Parent or Guardian_____Driver's License_____
(If under 18 years of age)

Date: _____

Authorization for release of medical information

I authorize, _____ to release all requested medical information not limited to notes, office and operative reports, x-rays / results, scans, lab results, etc. to Universal Physical Therapy, so that they can provide me with the best care possible. This authorization will expire one year from now.

Print Name:_____Date of Birth:_____/_____/_____

Signature:_____Date:_____