ERGONOMICALLY CORRECT, LLC

65 Old Solomon's Island Rd, Suite 104, Annapolis, Maryland 21401
Office: (410) 266-8500 * Fax: (410) 266-8520

Patient Information

Thank you for choosing our practice for your physical therapy needs. Please complete this form in print and ink or electronically and print for initial visit. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help you.

Name: _____ Date: _____ SS/HIC/Patient ID# _____
First Middle Initial Last

Address: _____ City: _____ State: _____ Zip: _____

Sex: ☐ Female ☐ Male Birth Date: _____ E-Mail: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Cell ☐ No Preference

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School: _____ Occupation: _____

Employer/School Address: _____ City: _____ State: _____ Zip: _____

Spouse/Parent's name: _____ Employer: _____ Phone: _____

Whom may we thank for referring you to us? _____

Person to contact in case an emergency: _____ Phone: _____

Responsible Party

Name of person responsible for this account: _____

Relationship to patient: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Employer: _____ Work Phone: _____

Insurance Information

Name of insured: _____ Relationship to patient: _____

Birth Date: _____ Social Security # _____ Date employed: _____

Name of Employer: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Co. _____ Phone: _____ Group# _____ Employer # _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

If any, how much is your deductible? _____ If so, how much have you used? _____ Max. Annual Benefit? _____

DO YOU HAVE ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, PLEASE COMPLETE THE FOLOWING:

Name of insured: _____ Relationship to patient: _____

Birth Date: _____ Social Security # _____ Date employed: _____

Name of Employer: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Co. _____ Phone: _____ Group# _____ Employer # _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

If any, how much is your deductible? _____ If so, how much have you used? _____ Max. Annual Benefit? _____

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Symptoms

Reason for visit: _____ When did you first notice the symptoms? _____
Is this condition getting progressively worse? _____
Where specifically is the problem(s) located? _____
Which activities are difficult to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ Other

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

Rate the severity of your pain. *(1, mild pain or discomfort to 10, severe pain)*: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Is the pain constant or does it come and go? _____
What treatment have you already received for your condition?
☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Other _____
Name and address of other doctor(s) who have treated you for your condition:
_____

Health History

Check only those conditions which are applicable:

☐ AIDS/HIV	☐ Cataracts	☐ Hepatitis	☐ Osteoporosis	☐ Suicide Attempt
☐ Alcoholism	☐ Chemical Dependency	☐ Hernia	☐ Pacemaker	☐ Thyroid Problems
☐ Allergy Shots	☐ Chicken Pox	☐ Herniated Disc	☐ Parkinson's Disease	☐ Tonsillitis
☐ Anemia	☐ Depression	☐ Herpes	☐ Pinched Nerve	☐ Tuberculosis
☐ Anorexia	☐ Diabetes	☐ High Cholesterol	☐ Pneumonia	☐ Tumors, Growths
☐ Appendicitis	☐ Emphysema	☐ Kidney Disease	☐ Polio	☐ Typhoid Fever
☐ Arthritis	☐ Epilepsy	☐ Liver Disease	☐ Prostate Problems	☐ Ulcers
☐ Asthma	☐ Fractures	☐ Measles	☐ Prosthesis	☐ Vaginal Infections
☐ Bleeding Disorders	☐ Glaucoma	☐ Migraine Headaches	☐ Psychiatric Care	☐ Venereal Disease
☐ Breast Lump	☐ Goiter	☐ Miscarriage	☐ Rheumatoid Arthritis	☐ Whooping Cough
☐ Bronchitis	☐ Gonorrhea	☐ Mononucleosis	☐ Rheumatic Fever	☐ Other_____
☐ Bulimia	☐ Gout	☐ Multiple Sclerosis	☐ Scarlet Fever	_____
☐ Cancer	☐ Heart Disease	☐ Mumps	☐ Stroke	_____

Dates of last exams: _____
(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No
List any types of surgeries which you have had and the dates which they occurred:
_____
Please list all medications you are currently taking: _____
_____
Allergies: _____

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Daily Habits

What type of exercise do you perform on a daily basis? ☐ None ☐ Moderate ☐ Heavy

What does your daily work habits include? (Example: sitting, standing, light labor, heavy labor, computer work)

_____

What vitamins do you currently take? _____

What kind of nutritional supplements do you take (if any)? _____

Do you smoke? ☐ Yes ☐ No How much a day (if yes)? _____

How much liquor do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company

and assign directly to _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named Physical Therapist may use my health care information and may disclose such information to above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable to related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient