BACK IN ACTION
PHYSICAL THERAPY

Indicates required information for insurance processing.

*Patient Name:_____ Today's Date: ____/____/____ *SSN_____
*Street Address:_____ Apt/Unit#: _____ *DOB ____/____/____
*City:_____ *State: _____ *Zip:_____ ◯ Male ◯ Female
Home Phone: _____ Cell/Other Phone: _____
Email Address:_____
Occupation:_____ Employer: _____
Emergency Contact: _____ Relationship to Patient: _____
Emergency Contact Number: _____
Family Physician: _____ Physician Phone: _____
Have you ever been seen in our office as a patient before this visit? ◯ Yes ◯ No If Yes, date of last visit: _____
In the event that we have to contact you, may we leave a message on your answering machine? ◯ Yes ◯ No

Is this a Worker's Compensation Claim? ◯ Yes ◯ No If yes, date of injury:_____ Claim# _____
Company Name: _____ Address: _____
Phone: _____ Contact Person: _____

Is this an Accident case? ◯ Yes ◯ No ◯ Vehicle ◯ Other:_____ Date of Accident: _____
Insurance Company to Bill: _____ Adjuster Name: _____
Address:_____
Phone: _____ Claim#: _____
Is there pending litigation concerning your injury? ◯ Yes ◯ No If yes, attorney name:_____
Attorney Address: _____ Attorney Phone: _____

How did you hear about Back In Action Physical Therapy?
◯ Friend ◯ Physician ◯ Yellow Pages ◯ Web site ◯ Other: _____
Referring Doctor Name and Phone: _____ Referring Friend Name: _____

I consent to BKR Therapies, Inc. dba Back in Action. for treatments/procedures that are necessary or advisable for my care. I hereby grant authorization to BKR Therapies, Inc. dba Back in Action to exchange with and/or release requested information on my medical care to my insurance carrier(s) and to:

◯ Patient/Guardian ◯ Worker's Compensation Attorney ◯ Rehabilitation Intermediary

I certify that the information furnished by me is correct and hereby direct and authorize payment of health care benefits due me by insurer to BKR Therapies, Inc. dba Back in Action. I understand that I am financially responsible for payment of fees regardless of insurance coverage. I also certify that I have received the initial patient information from BKR Therapies, Inc. dba Back in Action.
Print Name:_____ **Signature:**_____ **Date:**_____

I have read and understand BKR Therapies, Inc. dba Back in Action's privacy notice. I further understand that I may obtain a copy of this privacy notice upon my request.
Signature:_____ **Date:** _____

I have read and understand BKR Therapies, Inc. dba Back in Action's initial disclosure, cancellation and no show policies. I further understand that I may obtain a copy of this policy upon my request.
Signature:_____ **Date:** _____

Responsible party's name and signature, if patient is a minor: _____

BACK IN ACTION
PHYSICAL THERAPY

Patient Health History Form 1

Who do you live with? ◯ Alone ◯ Spouse Only ◯ Spouse and Other(s) ◯ Child ◯ Other Relative ◯ Group Setting ◯ Personal Care Attendant ◯ Other:

Has anyone in your immediate family (parents, brother, sisters) been treated for any of the following?

Diabetes	◯ No ◯ Yes	Headaches	◯ No ◯ Yes
Stroke	◯ No ◯ Yes	Epilepsy	◯ No ◯ Yes
Kidney Disease	◯ No ◯ Yes	Mental Illness	◯ No ◯ Yes
Alcoholism	◯ No ◯ Yes	Cancer	◯ No ◯ Yes
Tuberculosis	◯ No ◯ Yes	Arthritis	◯ No ◯ Yes
Heart Disease	◯ No ◯ Yes	Anemia	◯ No ◯ Yes
High Blood Pressure	◯ No ◯ Yes		

Have you ever been diagnosed with any of these conditions or have you recently experienced any of the following? ***Please check all that apply.***

◯ Allergies	◯ Fatigue	◯ Pace Maker
◯ Anemia	◯ Fever/Sweats/Chills	◯ Parkinson's Disease
◯ Anxiety	◯ Gall Bladder Problems	◯ Polio
◯ Arthritic Conditions (not RA)	◯ Hearing Problems	◯ Rheumatoid Arthritis
◯ Asthma	◯ Heart Attack/Heart Conditions	◯ Seizures/Epilepsy
◯ Cancer	◯ Hepatitis	◯ Speaking Problems
◯ Chemical Dependency (Alcoholism)	◯ High Blood Pressure	◯ Stroke
◯ Circulation Problems	◯ Incontinence/Bowel Problems	◯ Thyroid Problems
◯ Currently Pregnant	◯ Kidney Disease	◯ Tuberculosis
◯ Depression	◯ Metal Implants	◯ Vision Impairment
◯ Diabetes	◯ Multiple Sclerosis	◯ Weakness
◯ Dizziness/Light headed	◯ Nausea/Vomiting	◯ Weight Gain
◯ Emphysema/Bronchitis	◯ Numbness/Tingling	◯ Weight Loss
◯ Fractures	◯ Osteoporosis/Osteopenia	◯ Other:_____

At the present time, would you save your health is: ◯ Excellent ◯ Very Good ◯ Fair ◯ Poor

Do you ever feel unsafe at home or has anyone hit or injured you in any way? ◯ Yes ◯ No

How much caffeinated or caffeine containing beverages do you drink per day? _____

Do you smoke cigarettes? ◯ Yes ◯ No If Yes, how many per day? _____

Do you drink alcohol? ◯ Yes ◯ No If Yes, how many drinks per day/week? _____

Do you perform regular exercise? ◯ Yes ◯ No If Yes, how often? _____

Please list any allergies. _____

Which of the following over-the-counter medications have you taken in the last week? ***Please check all that apply.***

◯ Aspirin ◯ Tylenol ◯ Advil/Motrin/Ibuprofen Laxatives ◯ Antihistamines ◯ Antacids ◯ Decongestants ◯ Vitamins/Mineral Supplements ◯ Other: _____

Please list all Vitamins/Supplements you are currently taking: _____

Please list all Prescriptions you are currently taking: _____

_____

_____

Do any of your medications cause you to be dizzy or lose your balance? ◯ Yes ◯ No

Print Name: _____ **Signature:** _____ **Date:** _____

BACK IN ACTION
PHYSICAL THERAPY

Patient Health History Form 2

Height: _____ Weight: _____

Have you ever been hospitalized and/or had major surgery? ◯ Yes ◯ No
If Yes, please provide details: _____

Your Current Condition

Where or how did your injury/symptoms occur? ◯ Recreation ◯ Home ◯ Auto Accident ◯ Work ◯ Unknown ◯ Other: _____

What activities are limited by your injury (ie lifting, standing, etc.)? _____

For this injury, please check all medical care that you have received thus far.

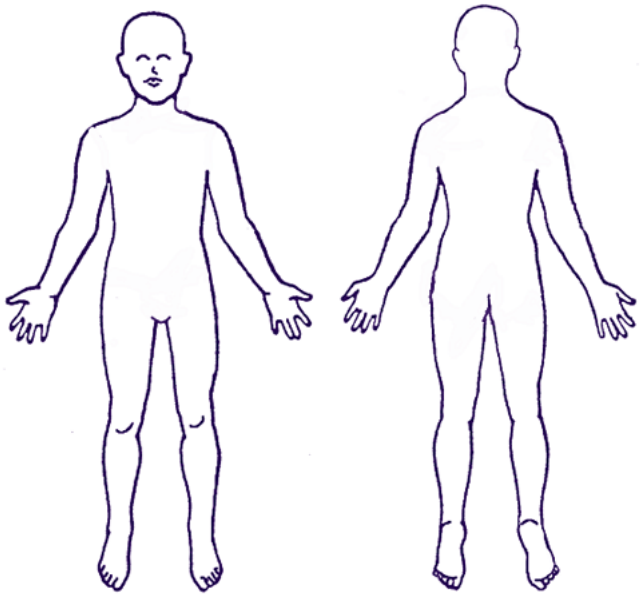
- ☐ Surgery — When? _____ What kind? _____
- ☐ Injection — When? _____ Where? _____ Did it help? _____
- ☐ Prior physical therapy — When? _____ What was done? _____
- ☐ Home Health — When? _____
- ☐ Chiropractor — When? _____ What was done? _____
- ☐ X-Ray ◯ MRI ◯ CT Scan ◯ NCV (Nerve Conduction Velocity) ◯ Other:
- ☐ Exercises: _____

Are your symptoms: ◯ Constant? ◯ Intermittent? ◯ Getting better? ◯ Getting worse? ◯ No change?

Please rate your major area of pain on the 0 – 10 Pain Rating Scale by circling the number of your pain where 0 is "no pain" and 10 is "unbearable pain."

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

Please indicate where on the body you are having pain.



Print Name: _____ **Signature:** _____ **Date:** _____