PATIENT INFORMATION

NAME:		First time patient? ▫ Yes ▫ No	
Address:			
City:		ST.	Zip
Home telephone: ( )	Cell phone: ( )		
Social Security No.:	D.O.B.		
EMPLOYER AT TIME OF INJURY:	Occupation:		
Address:			
City		ST.	Zip
Work Telephone: ( )	Contact Person:		
CURRENT EMPLOYER: ▫ Same as above			
In case of an on-site emergency, I.W.R. should notify:			
Relationship to patient:		Telephone:	

CONSENT FOR TREATMENT: I, the undersigned, understand that my treatment is under the direction of my referring physician and consent to prescribed treatment.

All clients filing an open and approved Workman's Comp claim are excluded from any charges incurred by I.W.R. Therapy Systems

RELEASE OF INFORMATION: I authorized I.W.R. to release any and all information required in the course of my examination and treatment in connection with therapy treatments for any and all purposes involved in medical treatment, professional services and/or billing. This consent and authorization specifically includes but is not limited to: psychological, psychiatric, alcohol, drug abuse, and HIV/AIDS information.

NON-DISCRIMINATION: Admission to our clinic is non-discriminatory for services rendered, regardless of race, color, national origin, disability, or age. All clients who come to our clinic for services are protected against discrimination assured by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

LEGAL AUTHORIZATION: I authorize I.W.R. Therapy Systems in 1) the collection of benefits from any responsible third party through whatever means may be deemed necessary, and 2) the endorsement of benefit checks made payable to myself or to I.W.R. Therapy Systems.

SCHEDULING: We take scheduling very seriously because it can make the difference between whether you succeed in your treatment or not. Your treatment will have a set frequency (Example 2 or 3 times per week). Cancellations and no-shows are documented if you do not attend at this frequency. Documentation of any missed appointment will be forwarded to your adjuster, case manager and primary physician which can jeopardize your claim.

When you don't show as scheduled, three people are hurt: You because you don't get the treatment you need as prescribed by the doctor and/or PT; the therapist who now has a space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice.

I, the undersigned, certify that I have read and understand the above.

Client Signature: **Today's Date:**

PAST MEDICAL HISTORY QUESTIONNAIRE

Name:_____Height:_____Weight:_____

Reason for Physical Therapy evaluation:_____

Location of Injury / Pain:_____

List of current medications you are taking:_____

List of any allergies to medication:_____

Check the boxes that apply to your medical history and explain if applicable.

▫ Angina:

▫ Ankle Swelling:

▫ Arthritis:

▫ Asthma:

▫ Back Injury:

▫ Black Outs:

▫ Cancer:

▫ Diabetes:

▫ Dizziness/Vertigo:

▫ Epilepsy:

▫Heart Abnormality:

▫ Heart Attack:

o Chest Pain:

▫ Hernia:

▫ High Blood Pressure:

▫ High Cholesterol:

▫Kidney Disease:

▫ Liver Disease:

▫Muscle cramping:

▫ Muscle spasms:

▫ Neck Pain:

▫ Pace Maker Implant:

▫ Prosthesis/Brace:

▫Headaches:

▫ Seizures:

▫Shortness of Breath:

▫ Stroke / CVA:

▫ Surgery:

Patient
Signature:_____Date:_____