SWANNER PHYSICAL THERAPY
1202 Maricopa Hwy., Suite B • Ojai, California 93023
805 646 6313 • Fax 805 646 6318

NEW PATIENT INFORMATION

Patient Name:_____ Date of Birth:_____ Age:_____

Address:_____ Social Security Number:_____

City, State, Zip:_____ Home Phone:_____

Cell Phone:_____ Work Phone: _____

Email:_____

Preferred method of communication: Text _____ Email _____ Phone _____

Primary Care Physician:_____

Employer:_____ Occupation:_____

Address:_____ City, State, Zip: _____

Are you a student? Yes _____ No _____ School:_____

Is your injury work-related? Yes _____ No _____ If yes, date of injury:_____

Is this a personal injury or motor vehicle accident? Yes ___ No ___ If yes, date of injury:_____

Do you have an attorney involved in this case? Yes _____ No _____

If yes, please provide: Name _____ Phone Number _____

Street Address: _____ City, State, Zip: _____

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD

I authorize payment of medical benefits to "Swanner Physical Therapy" as indicated on the itemized bill. I authorize Swanner Physical Therapy to release medical billing information required to process claims for payment or as necessary for care in the course of my therapy. I understand that Swanner Physical Therapy is billing my insurance as a courtesy, and that I am ultimately responsible for the charges.

Signature _____ **Date** _____

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Name: _____ Email: _____

CURRENT AND PAST MEDICAL HISTORY

AS FAR AS YOU ARE CONCERNED, WHAT BRINGS YOU INTO PHYSICAL THERAPY? _____

_____

WHEN DID IT START? _____

WHAT ARE YOUR GOALS FOR PHYSICAL THERAPY? _____

DID YOU HAVE SURGERY FOR THIS PROBLEM? _____ WHEN? _____

RESULTS OF X-RAYS, MRI OR SPECIAL TESTING _____

CURRENT MEDICATIONS: (NONE ____): _____

_____

DO YOU HAVE OR HAVE YOU EVER HAD:		EXPLAIN:
DIZZINESS OR VERTIGO?	YES _____ NO _____	_____
RHEUMATOID ARTHRITIS?	YES _____ NO _____	_____
NEUROLOGICAL DISORDER?	YES _____ NO _____	_____
DIABETES?	TYPE I _____ TYPE II_____ NO _____	_____
HEART PROBLEMS OR HEART DISEASE?	YES _____ NO _____	_____
PACEMAKER?	YES _____ NO _____	_____
PRIOR SURGERIES?	YES _____ NO _____	_____
SEIZURES?	YES _____ NO _____	_____
METAL IMPLANTS?	YES _____ NO _____	_____
ALLERGIES?	YES _____ NO _____	_____
A STROKE?	YES _____ NO _____	_____
CANCER?	YES _____ NO _____	_____
OSTEOPOROSIS?	YES _____ NO _____	_____

HOW IS YOUR OVERALL HEALTH? GOOD ____ FAIR ____ POOR____ ACTIVITY LEVEL? LOW ____ MED ____ HIGH ____

ARE YOU PREGNANT? YES _____ NO _____

ARE YOU CURRENTLY WORKING? YES _____ NO _____

IF YOU ARE NOT WORKING IS IT BECAUSE OF YOUR INJURY? YES _____ NO _____

I AUTHORIZED PAYMENT OF MEDICAL BENEFITS TO "SWANNER PHYSICAL THERAPY" AS INDICATED ON THE ITEMIZED BILL. I AUTHORIZE SWANNER PHYSICAL THERAPY TO RELEASE MEDICAL AND BILLING INFORMATION REQUIRED TO PROCESS CLAIMS FOR PAYMENT OR AS NECESSARY FOR CARE, IN THE COURSE OF MY TREATMENT.

SIGNATURE _____ DATE _____

DATE OF BIRTH _____ PHONE NUMBER _____