evolve
PHYSICAL THERAPY AND SPORTS

Welcome to the Evolve Physical Therapy and Sports, LLC. We are committed to providing the best, most comprehensive orthopaedic care possible. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks, if you need assistance filling out this form please notify the receptionist. All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

DEMOGRAPHICS (Please print all information)		
Name *(First, M.I., Last):* ☐ M ☐ F		**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other		**Age:**
Race/Ethnicity: ☐ African American ☐ Caucasian ☐ Hispanic ☐ Asian ☐ Other		
Address:		
City:	**State:**	**Zip:**
Home Phone:	**Cell:**	**Work:**
Email Address:		**Contact Via:** ☐ Cell ☐ Home ☐ Email
If a minor, name of guardian & relationship:		
NOTIFY IN CASE OF EMERGENCY		
Name:	**Relationship:**	
Home Phone:	**Cell:**	**Work:**
BILLING		
Who is the Guarantor on the Account?		**DOB:**
Primary Insurance Company Name:		☐ PPO ☐ HMO
Member ID:		
Name of Insured:		**Insured DOB:**
Secondary Insurance Company:		☐ PPO ☐ HMO
Member ID:		
Name of Insured:		**Insured DOB:**
INJURY/SYMPTOMS		
What is your diagnosis or injured body part?		
Date of Injury/Onset of Symptoms:		
How did the injury occur?		
Is this injury work related?	☐ Yes	☐ No
If yes, was the injury reported to your employer?	☐ Yes	☐ No
Please list all physicians seen for this problem:		
Who can we thank for referring you to our clinic?		

I hereby assign my insurance benefits plan for medical services rendered to Evolve Physical Therapy and Sports, LLC. I understand that I am financially responsible for any charges not covered by this assignment; payment of all services rendered, regardless of insurance coverage or other third-party liability; and pay all costs of collection, including reasonable attorney fees and court costs in the event it becomes necessary to pursue the account for collection. I also hereby authorize the release of information required in the course of my examination as may be needed to process my insurance.

Signature: Date:

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

SOCIAL HISTORY

Alcohol	Do you drink alcohol?	☐ Yes ☐ No
	How many drinks per week?	
Tobacco	Do you use tobacco?	☐ Yes ☐ No
	☐ Current every day smoker If yes, _______________ pack(s)/day _______________ packs(s)/week	
	☐ # of years smoked ☐ Current some day smoker ☐ Former smoker ☐ Never smoked	

FAMILY MEDICAL HISTORY

Illness		**Illness**	
Cancer	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Heat Attack/Disease	☐ Yes ☐ No	Degenerative Arthritis	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Immune Disorders	☐ Yes ☐ No

REVIEW OF SYSTEMS

CONSITUTIONAL SYMPTOMS	**YES**	**NO**	**GASTROINTESTINAL**	**YES**	**NO**	**NEUROLOGICAL**	**YES**	**NO**
Recent weight change			Loss of appetite			Frequent headaches		
Fever			Nausea or vomiting			Light headed or dizzy		
Unexplained sweating			Frequent diarrhea			Seizures		
EYES			Constipation			Numbness or tingling		
Wear glasses or contacts			Rectal bleeding or blood in stool			Tremors		
Blurred or double vision			Black tarry stools			Paralysis		
Glaucoma			Regular abdominal pain or heartburn			**PSYCHIATRIC**		
ENT			**GENITOURINARY**			Memory loss or confusion		
Hearing Loss			Frequent urination			Anxiety		
Regular nose or gum bleeding			Burning or painful urination			Depression		
Sore Throat			Blood in urine			Insomnia		
Swollen glands in neck			Incontinence or dribbling			**ENDOCRINE**		
CARDIOVASCULAR			Female: # __________ of pregnancies			Glandular or hormone problem		
Irregular heart beats			Female: # __________ of miscarriages			Excessive thirst or urination		
Shortness of breath w/walking or lying flat			**MUSCULOSKELETAL**			Heat or cold intolerance		
Swelling in feet, ankles, and hands			Joint pain			Changes in hair or nails		
Fainting spells			Joint stiffness and swelling			**HEMATOLOGY**		
Elevated cholesterol			Morning stiffness			Bruising tendency		
RESPIRATORY			Difficulty walking			Anemia		
Chronic or frequent coughing			Muscle cramping			Need for past transfusion		
Spitting up blood			**INTEGUMENTARY**			**Patient: Please provide ht. & wt.**		
Regular shortness of breath			Rash or itching			Height: ________________________		
Emphysema			Changes in skin color			Weight: ________________________		
Regular wheezing			Varicose veins					

ALLERGIES: Do you have a history of latex allergy? ☐ Yes ☐ No Do you have a history of adhesive tape allergy? ☐ Yes ☐ No

DRUG	**REACTION**	**DRUG**	**REACTION**
1.		3.	
2.		4.	

PAST SURGICAL HISTORY

YEAR	**NAME OF OPERATION**	**TYPE OF ANESTHETIC (GENERAL, REGIONAL, LOCAL)**	**COMPLICATIONS**

ILLNESS/INJURY	**YES**	**NO**	**ILLNESS/INJURY**	**YES**	**NO**
Hight blood pressure			Kidney disease		
Diabetes			Liver disease		
Heart attack/disease			Females ONLY: Are you or could you be pregnant?		
Chest pain or angina			AIDS or HIV infection		
Stroke			Thyroid problems		
Cancer			Shortness of breath		
Hepatitis			Blood clots		
Stomach ulcers			Bleeding tendency		
Arthritis			Pacemaker		
Gout			Accidents/Broken bones (please list:)		
Osteoporosis					

MEDICATIONS

DRUG	DOSAGE	DRUG	DOSAGE
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Do you take diet pills or nutritional supplements? ☐ Yes ☐ No
If Yes, please list the type and when last taken:

NAME	DATE LAST TAKEN
1.	
2.	

IMMUNIZATION HISTORY:
When was your last tetanus shot? ____

MEDICAL HISTORY PATIENT CONSENT
I agree that Evolve Physcial Therapy and Sports, LLC may request and use my medical history from other healthcare providers or third-party pharmacy payors for treatment purposes. ☐ Yes ☐ No

EVOLVE PHYSICAL THERAPY AND SPORTS, LLC

I agree that Evolve Physical Therapy and Sports, LLC may request and use my prescription medication history from other healthcare providers or third-party pharmacy payors for treatment purposes. ☐ Yes ☐ No

When you return this form to the receptionist, **please bring your insurance card**. We cannot bill your insurance unless you give us your current, accurate insurance information.

As a courtesy to you, we will bill your insurance company for services provided. All co-payments and unsatisfied deductibles must be paid at time of service. Our office expects payment in full from your insurance within 90 days unless otherwise specified by a contract with your insurance provider. In the event that your insurance makes payment at a later date, all overpayments will be refunded to you.

I have read and understand that I am ultimately responsible for all fees regardless of insurance coverage including any legal or other cost incurred in the collection of this account if it becomes delinquent. I authorize Evolve Physical Therapy and Sports, LLC to release any medical information necessary to process insurance forms. I further authorize payment of medical benefits to Evolve Physical Therapy and Sports, LLC.

____ ____________________
Signed Date

____
Printed Name:

Acknowledgement of Receipt of Privacy Notice
Effective February 1, 2019

I have been presented with a copy of Evolve Physical Therapy and Sports, LLC's Notice of Privacy Policies detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning my personal medical information:

____ ____________________
Signed Date

____
Printed Name:

The person listed below has my permission to discuss my medical information:

Name: ____________________________ Relationship: ____________________________

Name: ____________________________ Relationship: ____________________________