1720 SE Haig St
Portland, OR 97202
Phone: (305)979-9836
www.fuerzapt.com

FUERZA
PHYSICAL THERAPY

Name:_____ Today's Date: _____

How did you hear about Fuerza PT?_____

Is it ok to receive emails from Fuerza PT? ☐ YES ☐ NO

Primary Insurance

Insurance carrier:_____ Plan Name:_____

ID/Subscriber #:_____ Group #: _____

Primary on policy?: ☐ YES ☐ NO, if no, what is the primary insured ID #:_____

Legal name: _____ DOB: ____/_____/____ Relationship to you: _____

Secondary Insurance *if applicable*

Insurance carrier:_____ Plan Name:_____

ID/Subscriber #:_____ Group #: _____

Primary on policy?: ☐ YES ☐ NO, if no, what is the primary insured ID #:_____

Legal name: _____ DOB: ____/_____/____ Relationship to you: _____

Motor Vehicle or Work Accident claim *if applicable*

Insurance carrier:_____ Claim #:_____ Claim submitted? ☐ Y ☐ N

Date of injury:_____/_____/_____ In: _____ State Adjuster's Name:_____

Claims address:_____ _____ Carrier/adjuster phone:_____

Attorney's name: _____ Phone: _____

By signing below, I verify that the above information is correct and true to the best of my knowledge. I am responsible for payment of all professional fees. If we have agreed to bill a third party and that party fails to make payments, we will notify you in writing and arrange a payment schedule. You are required to pay all non-allowable, copayments, and deductible charges at the time of service. Defaulted accounts may be sent to collection, and if an attorney is hired to collect the outstanding balance and occurring charges, you agree to pay all costs and attorney fees incurred. You are responsible for coming to your session at the scheduled time. If you are unable to keep an appointment please notify us ASAP at (305)979-9836. If an appointment is missed you will be billed $25 for the session. Missed sessions cannot be billed to insurances. You are responsible for telling us when you wish to conclude treatment.

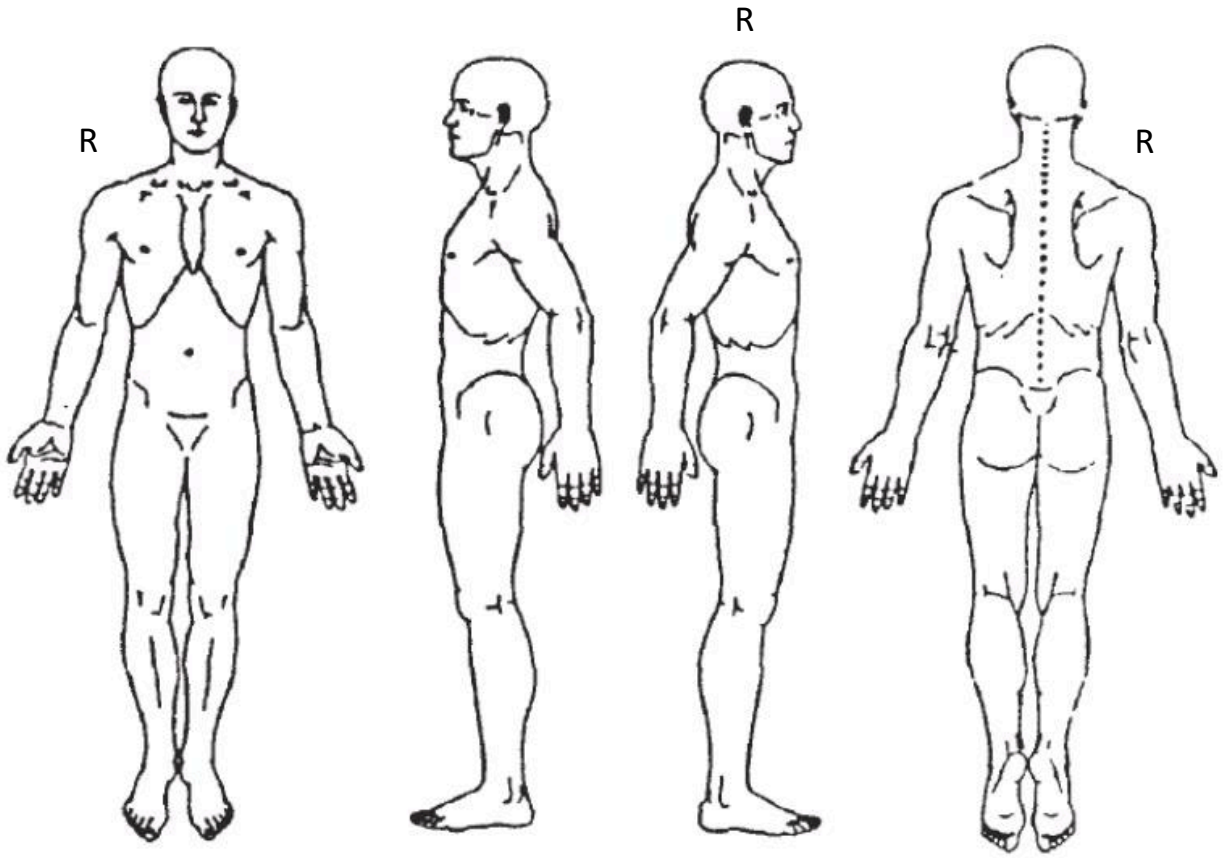
_____ _____
Patient or Guardian Signature Date

Health History

Reason for physical therapy visit *(indicate date of surgery if applicable)*: _____

_____

Localize areas of pain or abnormal sensation on the body chart below (shade in where appropriate):



Are you currently under the care of a physician? ☐ Y ☐ N If yes, explain: _____

_____

Name of physician: _____ Phone: _____

Date of last visit to physician: ____/____/_____ Do you have a referral for physical therapy? ☐ Y ☐ N

Please list any health problems: _____

_____

_____

Please list any prescription or over the counter medications you are taking: _____

_____

Have you ever had physical therapy before? ☐ Y ☐ N If yes, explain _____

_____

Please check if you have had any of the following:

__ Coronary Heart Disease
__ Heart Attack
__ Angina
__ High Blood Pressure
__ Congestive Heart Failure
__ Irregular Heartbeats
__ Congenital Heart Disease
__ Peripheral Vascular Disease
__ Diabetes
__ Stroke
__ Epilepsy
__ Hernia
__ Bowel/Bladder Problems
__ Osteoporosis
__ Cancer
__ Recent Weight Loss
__ Infectious Diseases
__ Shortness of Breath
__ Dizziness/Fainting
__ Asthma
__ Emphysema
__ Systemic Disease
__ Eating Disorder
__ COPD
__ Allergies

Orthopedic/Muscular Problems or Surgeries

__ Back Pain
__ Foot Injuries
__ Shoulder Injuries
__ Neck Injuries
__ Knee Injuries
__ Broken Bones
__ Joint, Tendon, or Muscular Pain
__ Arthritis (Osteo)
__ Arthritis (Rheumatoid)

Please explain any of the above (include surgery date): _____

_____

_____

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