1977 Dewar Drive Suite J
Rock Springs, WY 82901
www.aptwy.com

(307) 382-3228 Phone
(307) 382-6886 Fax

Alliance Physical Therapy

520 Wilkes Drive Suite 17
Green River, WY 82935
www.aptwy.com

(307) 875-1788 Phone
(307) 875-8817 Fax

Date: / /

Patient Name:	Date of Birth: / /	Social Security: / /	Marital Status S M D W	Sex: ☒ M ☐ F
Home Address:	City:	State:	Zip:	
Billing/Mailing Address:	City:	State:	Zip:	
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )	Email:	
Employer:	Emergency Contact:	Relationship to Patient:	Telephone: ( )	
Referring Doctor:	Date of Injury: / /	Date of Surgery: / /		
Injury Type: Work Related? ☐ Yes ☐ No	Auto Accident? ☐ Yes ☐ No	Other Accident? ☒ Yes ☐ No		

If this is a Worker's Compensation claim: Employer at Time of Injury:	Brief description of accident: (Where you were? How it happened?)
Claim Number:	
Case Manager Name:	Case Manager #:

How did you hear about us?

☐ Physician/ Hospital ☐ Internet Search ☐ Returning Patient ☐ Word of Mouth

Primary Insurance:

Insurance Company:	Policy Holder:	Policy Holder DOB: / /	Policy Holder Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other
ID/Policy No:	Group No:	Employer:	Social Security:

Secondary Insurance:

Insurance Company:	Policy Holder:	Policy Holder DOB: / /	Policy Holder Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other
ID/Policy No:	Group No:	Employer:	Social Security:

Are you currently taking medications? If yes, please list below or provide a medication list.		
Medication	**Dosage**	**Frequency of Dosage**

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Patient Health History:

Height: Weight: Age: Family Physician:

Please mark if you ever had:

- ☐ Alzheimer's
- ☐ Cardiovascular Disease
- ☐ Cauda Equina Syndrome
- ☐ Cerebral Vascular Accident
- ☐ Current Infection
- ☐ Diabetes Mellitus Type 1
- ☐ Diabetes Mellitus Type 2
- ☐ Fibromyalgia
- ☐ Fracture Or Suspected Fracture
- ☐ High Blood Pressure
- ☐ History Of Cancer
- ☐ Huntington's
- ☐ Immunosuppression
- ☐ Lupus
- ☐ Muscular Dystrophy
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Parkinson's
- ☐ Rheumatoid Arthritis
- ☐ Traumatic Brain Injury
- ☐ Stroke
- ☐ Asthma/Allergies
- ☐ Hepatitis
- ☐ Thyroid Problems
- ☐ Pregnant
- ☐ Pacemaker
- ☐ Lung Disease/Problems
- ☐ Heart Disease/Problems
- ☐ Circulation/Bleeding Problems
- ☐ Epilepsy/Seizures

Primary Concern/ Chief Complaint:

When did the symptoms appear?:

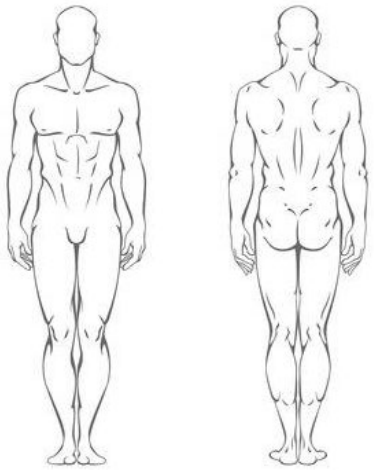
Is this condition getting worse?

☐ Yes ☐ No ☐ Same

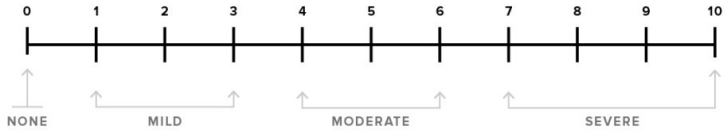
Are you currently working? ☐ Yes ☐ No

Mark on the diagram below the areas currently affected by your condition

X-Pain
0-Numbness
!!-Pins & Needles



Please indicate your pain level on the scale below



Please circle which goals you wish to achieve from attending therapy:

- ☐ Regain mobility
- ☐ Regain previous level of activity
- ☐ Return to work
- ☐ Maintain independent daily living
- ☐ Decrease pain
- ☐ Other:

Falls (please check all that apply)

- ☐ I have no falls
- ☐ I fall occasionally
- ☐ I fall frequently (more than twice in the last 6 months)
- ☐ I have just started to lose my balance
- ☐ Certain factors make me cautious (curbs, ice, stairs, and getting out of the tub)

What treatments have you already received for your condition?

☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Other

Please list past surgeries and dates:	
1.	4.
2.	5.
3.	6.

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Consent to Treatment:

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination and treatment. I have received and/or read a copy of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Policy.

Financial Responsibility and Assignment of Benefits:

I understand and agree that, I am ultimately responsible for the balance of my account for any professional services rendered, durable medical equipment (DME) fit, or splints applied. ***If I choose to not pay any outstanding balance, I could be responsible for court costs and attorney's fees, and interest charges of 1.5% monthly or 18% annually on any outstanding balance not paid that is sent to small claims court.*** In the event of collection procedures, attorney fees and court costs are your responsibility. ***I also understand that the delinquency fee with regards to collections will be equal to 50% of the principal amount owed.*** **(_____)**Initial

Cancellation/No Show Policy

I will kindly give as much notice as possible in the event that I need to cancel a scheduled appointment. Any appointment that is not cancelled or rescheduled prior to or within the time allotted for my appointment will be considered a no-show. ***After 3 such instances I understand that I may be formally discharged as a patient and my Doctor or Case Manager will be notified of this action.*** **(_____)**Initial

I certify that I have read this form and understand its contents.

Patient/Parent/Guardian Signature _____ Date _____

_____ _____

Printed Name Relationship to Patient