O'NEILL PHYSICAL THERAPY
227 N. CLEVELAND AVE· HAGERSTOWN, MD 21740
301-733-3844·301-733-3804 FAX
physicaltherapy@myactv.net

PATIENT NAME: _____ M/F Date of Birth___/___/_____

Social Security #: _____-_____-_____ Email Address:_____

Phone number: Primary (_____)_____-_____ Secondary (_____)_____-_____

Address: _____ City: _____ State:____ Zip:_____

Can we discuss your medical information with someone? YES/NO Name: _____
Can we leave a detailed message on your answering machine/voicemail? YES/NO

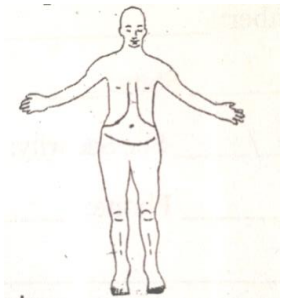
Emergency Contact: _____ Phone: _____

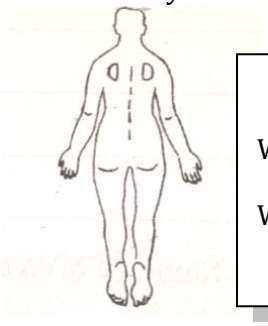
Referring Physician: _____ Family Physician: _____

Other physicians that should receive your physical therapy reports: _____

Who may we thank for referring you to O'Neill Physical Therapy? _____

Reason you were referred: _____ Date symptoms began: _____/_____/____
On the diagrams below, please indicate your major area of pain or disability





Severity of your symptoms (Please circle)											
With rest	0	1	2	3	4	5	6	7	8	9	10
With activity	0	1	2	3	4	5	6	7	8	9	10

My symptoms improve with: _____worsen with: _____

Please list any previous treatment for your condition: _____

Do you have or had in the past: **(PLEASE CIRCLE)**

Pregnant **NOW/DUE DATE**: _____	Parkinson's	Cancer:
History of back or neck problems	Multiple Sclerosis	kind/when
Jaw Pain	CVA/Stroke/TIA	
Arthritis	Cardiac Problems	
Rheumatoid Arthritis	High Blood Pressure	
Fibromyalgia	Lung Disorders	
Osteoporosis	Allergies/Asthma	Latex Allergy
Steroid use for more than two months	Diabetes	
Migraines/Headaches	Peripheral neuropathy	
Dizziness, vertigo, balance problems	Recent weight loss/gain	
Seizures	Urinary or fecal incontinence	Other:

Surgeries & dates: _____

Medications/vitamins/supplements: _____

In the past two months, have you or are you currently receiving health care services at home? Nurse and/or Aide? YES_____ NO_____ If yes, please see receptionist before continuing. Thank you

Is your injury pain due to a Motor Vehicle Accident*: _____ Workman's Compensation: _____

If yes, date of accident/injury: _____ Claim # _____

ADJUSTER/CASE MANAGER NAME (IF MVA OR WC) _____

Insurance company_____ Phone #_____

Attorney name: _____ Phone #_____

*If this is an MVA, we still need you to fill out the information below. Thank you

PRIMARY INSURANCE COMPANY: _____

Policy number: _____ Group number: _____

Policy holder's name: _____DOB _____/_____/_____Social Security #_____-_____-_____

Employer: _____Address: _____ Phone # _____

SECONDARY INSURANCE COMPANY: _____

Policy number: _____ Group number: _____

Policy holder's name: _____ DOB_____/_____/_____Social Security # _____-_____-_____

Employer: _____ Address: _____ Phone # _____

By signing below, I hereby attest that I have provided all insurance coverage applicable for services performed at this time. In the event that there is insurance coverage requiring pre-certification and it is not disclosed at the time of service, I will be held responsible for any outstanding balance. I understand that I am responsible for notifying O'Neill Physical Therapy if my insurance coverage changes, if I fail to notify them, I will be financially responsible for any services that are not covered by insurance. I understand that I am responsible for co-payments and deductibles at the time of service. I understand failure to pay the co-payments and deductibles will result in cancellation of my appointment and that I will be charged the cancellation fee. I understand that the charges may be more than my insurance company will cover and I am responsible for the balance due on my bill.

I authorize O'Neill Physical Therapy to release information from patient records to any insurer of the patient and to the other agencies or individuals providing medical or social services to the patient. Consent is given for the release of information and records to O'Neill Physical Therapy from all other agencies or individuals from where the patient has received medical or social services. I hereby authorize the insurance company or law firm representing me to pay "O'Neill Physical Therapy directly for services I receive.

INFORMED CONSENT: I am aware that I am undergoing physical therapy. Benefits may include relief of pain and improvement of function. Risks may include temporary aggravation of symptoms, pain or other adverse effects. Should I note a change in my symptoms, I am responsible for informing my physical therapists. I consent to treatment including, but not limited to, therapeutic exercise, electric stimulation, hot packs, cold pack, ultrasound, gait training, functional training, taping, paraffin, biofeedback, traction, iontophoresis, joint and soft tissue mobilization and manipulation.

I acknowledge having had the opportunity to review and receive a copy of O'Neill Physical HIPPA privacy policies.

I recognize the 24 hour notice (one business day) for cancellation of appointments is required. If I fail to give proper notice, I (not my insurance company) will be billed a 30.00 fee. Missing 2 appointments may result in discharge from physical therapy.

Please sign and date: (1 line per initial visit)

Signature: _____ Date: _____