Alyeska Therapy Center, Inc.

Patient Information Form

Patient Information

Last Name _____ First Name _____ MI _____ SSN _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Gender _____ Marital Status _____ Email _____

Emergency Contact

Last Name _____ Relationship _____

First Name _____ Phone _____

Employer

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

Problem

Problem Description _____ Date of Injury _____ Last Physician Visit / /

Referred By _____ Primary Care Physician _____

Latest Referral Information _____ Motor Vehicle Accident _____

Latest Plan of Care _____ That occurred in: _____

Notes: _____

Primary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Secondary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Tertiary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the Patient Registration form.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

(You have the right to refuse to sign this acknowledgement if you so choose.)

Signature: _____ Date: _____

Chief Complaint:
Describe the problem for which you seek physical/occupational/speech therapy.

_____

_____

Date of onset: / /
What happened?

_____

_____

Have you had this problem before? □YES □NO
If YES, a) What did you do for the problem? b) Did it help? c) How long did it last?

_____

_____

How are you taking care of the problem now?

_____

What are your personal goals for physical/occupational/speech therapy? For example, are there any particular activities that you would like to return to or complete?

_____

_____

Are you seeing anyone else for the problem(s)?

_____

What medications are you taking? (prescription and non-prescription)

_____

_____

Within the past year have you had any medical tests? (MRI, X-ray, EMG etc.)

_____

Medical History:

Please check if you have had any of the following problems:

□ Heart Condition	□ Lung Condition	□ Vision Loss
□ Pacemaker	□ Psychological	□ Artificial Joint
□ Circulatory Problems	□ Head Injury	□ Infectious Disease
□ Diabetes	□ Seizures/Epilepsy	□ Osteoporosis
□ Hypertension	□ Fractures	□ Arthritis
□ Stroke	□ Neck Injury	□ Surgery
□ Cancer	□ Back Injury	□ Allergies
□ Neurological Disease	□ Hearing Loss	□ Other

Brief history of surgeries and categories checked:

_____

Within the past year, have you had any of the following symptoms? (Check all that apply)

□ Chest pain
□ Heart palpitations
□ Persistent or productive cough
□ Hoarseness
□ Shortness of breath
□ Dizziness or blackouts
□ Weakness in arms or legs
□ Loss of balance
□ Falling
□ Difficulty walking
□ Joint pain or swelling
□ Pain at night
□ Difficulty sleeping
□ Loss of appetite
□ Nausea/Vomiting
□ Difficulty swallowing
□ Bowel problems
□ Weight loss or gain
□ Urinary problems
□ Fever/Chills/Sweats
□ Headaches
□ Other:_____

Brief history of symptoms checked:

Please describe any other medical history or information related to condition.