KAPPER PHYSICAL THERAPY

☐ **523 E. RAILROAD ST., SUITE A**
SANDWICH, IL 60548
PHONE: (815) 786-1888, FAX: (815) 786-1811

☐ **130 W. LINCOLN HWY.**
HINCKLEY, IL 60520
PHONE: (815) 286-7000, FAX: (815) 286-3106

Patient Name____**Date of Birth**_______________
(*first*) (*middle initial*) (*last*)

Address______________________________**City/State/Zip**____________________________________

Phone (*Home*)____________________**(*Work*)**_____________________**(*Cell*)**_____________________

Patient Social Sec. #________________________ **Marital Status** S M D W

Patient's Employer____

Patient's Employer Address_________________________**City**_______________**Zip**______________

(*Circle one*)

Name of Insured_______________________________**Relationship to patient: Self / Spouse / Parent**

Insured's Social Security#______________________________**Date of Birth**______________________

Insured's Employer____________________________________**Phone**___________________________

Insured's Employer Address_________________________**City**___________________**Zip**_________

Emergency Contact___________________________________**Phone**___________________________

Referring Physician___________________________________**Phone**___________________________

Physician's Address______________________________**City**___________________**Zip**___________

INSURANCE INFORMATION

Policy #___________________________________
Group #___________________________________
Insurance Co.______________________________
Address___________________________________
City/State/Zip_____________________________
Phone____________________________________

Please provide us with any supplemental insurance info.
If your insurance company requires a special form please provide this for us. –Thank you-

WORKER'S COMP CLAIMS

Date of Injury______________________________
Claim#____________________________________
Send claim to:______________________________
____
____
Claims Adjuster____________________________

Phone_____________________________________

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I understand and agree that regardless of insurance status, I am ultimately financially responsible for full payment for services rendered to me or my dependents in this office. In addition, any unpaid balance after 90 days will be subject to interest charges of 1 ½% per month, minimum of $2.50. All expenses incurred for collection of an unpaid balance after 90 days is the responsibility of the patient, parent or guardian.

I hereby authorize KAPPER PHYSICAL THERAPY to obtain or release all requested health information regarding care and treatment of myself or my dependents from/to insurance agencies, medical professional persons, and attorneys with authorized release. I also authorize payment directly to the above named physical therapy clinic of the medical and /or dental plan otherwise payable to me.

Signature_______________________________________**Date**______________________

I also authorize release of above mentioned information and payment to my secondary insurance company.

Signature_______________________________________**Date**______________________

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HISTORY FORM

Please provide us with the important background information on the following form. All information is considered confidential and will be released only to your physician unless prior written authorization is given. Thank you.

Name:____________________________________ Occupation:_________________________________

How did your hear about us?

□ Doctors referral	□ Insurance	□ Yellow Pages	□ Newspaper
□ Friend	□ Our Web Site	□ Previous Patient	□ Other________________________

Are you currently seeing any of the following for your condition?

YES	NO	Medical Doctor	YES	NO	Psychiatrist/Psychologist
YES	NO	Osteopath	YES	NO	Physical Therapist
YES	NO	Dentist	YES	NO	Chiropractor
YES	NO	Attorney	YES	NO	Massage Therapist

Have you ever been diagnosed with any of the following conditions?

YES	NO	Cancer, If yes, what kind: ______	YES	NO	Rheumatoid Arthritis
YES	NO	Heart Problems	YES	NO	Other arthritis
YES	NO	Circulation Problems	YES	NO	Hepatitis
YES	NO	High Blood Pressure	YES	NO	Tuberculosis
YES	NO	Asthma	YES	NO	Stroke
YES	NO	Emphysema/Bronchitis	YES	NO	Kidney Disease
YES	NO	Chemical Dependency	YES	NO	Anemia
YES	NO	Thyroid Problems	YES	NO	Epilepsy/Seizures
YES	NO	Diabetes	YES	NO	Depression
YES	NO	Multiple Sclerosis	YES	NO	Osteoporosis
YES	NO	Prostate Problems	YES	NO	Pregnancy (Currently/ Past 1 yr.)
YES	NO	Other__________________			

Please list any injuries, surgeries or other conditions for which you have been treated or hospitalized (including fractures, dislocation, sprains) within the last few years, including the approximate date of the procedure.

DATE INJURY/SURGERY/HOSPITALIZATION

____

____

____

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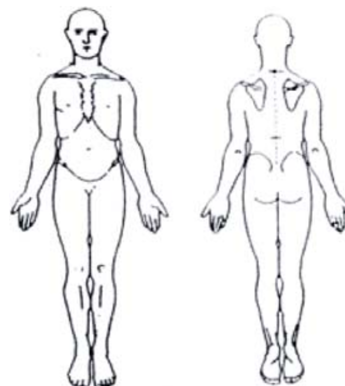
Please rate the severity of the symptoms/pain you are currently experiencing by circling the appropriate number.

	No Pain										Excruciating
• Currently, as you fill out this form	0	1	2	3	4	5	6	7	8	9	10
• At your best in the past 2 weeks	0	1	2	3	4	5	6	7	8	9	10
• At your worst in the past 2 weeks	0	1	2	3	4	5	6	7	8	9	10

Mark your present symptoms on the Body Chart.



List any activities you have difficulty performing as a result of your current problem.

____
____
____

List any PRESCRIPTION or OVER THE COUNTER medications you are taking.

____
____
____

Have you been seen by a home health agency in the last 60 days? YES NO
Have you been in the hospital or nursing home in the last 30 days? YES NO
If yes, date of discharge __________ Name of Hospital ___________________________.
Have you received prior outpatient therapy this year for the same condition? YES NO If different condition, please list date _____________ and condition.
____

Is there any other information you feel is important to your care?

____
____
____

Form reviewed with patient? YES NO

DATE_________________ PT Signature______________________________________