DEBBIE FONTENOT PHYSICAL THERAPY & WELLNESS, APMC

134 JOMELA DRIVE, LAFAYETTE, LA 70503

PATIENT INFORMATION			**Chart #: 011**
First Name:	Last Name:	Middle Initial:	Date:
Address:	City:	State:	Zip:
Birth date:	Age:	Sex:	S.S:
Home Phone:	Alternative Phone:	Spouse:	
CHIEF COMPLAINT:	E-mail address:		
DATE OF INJURY:	Referred to Clinic By:		

WORK INFORMATION		
Employer:	Work Phone:	Ext.
Occupation:	Employment Status:	

CARE PROVIDER INFORMATION		
Referring Dr:	Referring Dr. Phone:	Fax:
Regular Dr:	Regular Dr. Phone:	Fax:
Other Dr:	Other Dr. Phone:	Fax:

INSURANCE INFORMATION **(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)**	
Primary Insurance Name:	
Subscriber's Name (If different):	Birth date:
ID. #:	Group/Policy #
Patient's Relationship to Subscriber:	
Name of Secondary Insurance:	
Subscriber's Name:	Birth date:
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: Self Spouse Child Other:	

AUTO OR WORK INJURY CLAIM **(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)**			
Insurance Name: Auto : Labor & Industries:			
Adjuster/Claim Manager:	Phone:	Fax:	
Address:	City:	State:	Zip:
Claim #:	Accident Date:	Cause:	

ATTORNEY INFORMATION			
Name:	Law Firm:	Phone:	Fax:
Address:	City:	State:	Zip:

IN CASE OF EMERGENCY		
Name of Local Friend or Relative (Not Living at Same Address):		
Relationship to Patient:	Home Phone:	Work or Cell Phone:

I authorize my insurance benefits be paid directly to Debbie Fontenot Physical Therapy & Wellness. I understand that I am financially responsible for any balance. I also authorize Debbie Fontenot Physical Therapy & Wellness to release any information required to process my claims.

PATIENT / GUARDIAN SIGNATURE:	**DATE:**

PAST MEDICAL HISTORY FORM Patient Name _____

BLOOD PRESSURE	YES	NO	JOINT CONDITIONS	YES	NO
Hypertension			Upper Extremity		
Low Blood Pressure			Dislocation		
Normal Blood Pressure			Lower Extremity Dislocation		
HEART DISEASE	**YES**	**NO**	**OTHER CONDITIONS**	**YES**	**NO**
Heart Attack			Muscular Dystrophy		
Atherosclerotic Disease			Rheumatoid Arthritis		
Myocardial Infarction			Multiple Sclerosis		
Rheumatic Heart Disease			Epilepsy		
Heart Murmur			Gout		
Do you have a pacemaker			Fibromyalgia		
MUSCLE CONDITION	**YES**	**NO**	Diabetes		
Carpal Tunnel R/L			Hearing Loss		
Tennis Elbow R/L			Poor Eyesight		
Back/Neck Problems			Fainting		
Limited Limb Movement			Polio		
Other:					

LUNGS	YES	NO
Asthma		
Emphysema		
Shortness of Breath		

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS		
None	Sitting	Low	Smoking	Y or N	___ Packs a Day
1-2 x per week	Standing	Medium	Alcohol	Y or N	___ Drinks a Week
3-4 x per week	Light Labor	High	Coffee/Soda	Y or N	___ Cups per Day
5+ x per week	Heavy Labor				

What types of exercise do you perform? :

What things cause stress in your life? :

Are you taking any seizure medication?	YES	NO	If yes, list name:

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

YES	NO	If yes list name:

List all medications you are currently taking:

List all surgeries in the past two years (Including dates):

List all diagnostic tests in the past two years (X-Rays, MRI's, CT scans. Etc):

Are you pregnant?	YES	NO	What week?
Have you had any injuries related to work?	YES	NO	If yes list, body part and date:
Have you had any Auto Accidents?	YES	NO	If yes list, body part and date:
Have you had Physical Therapy or Massage Therapy before?	YES	NO	Where:

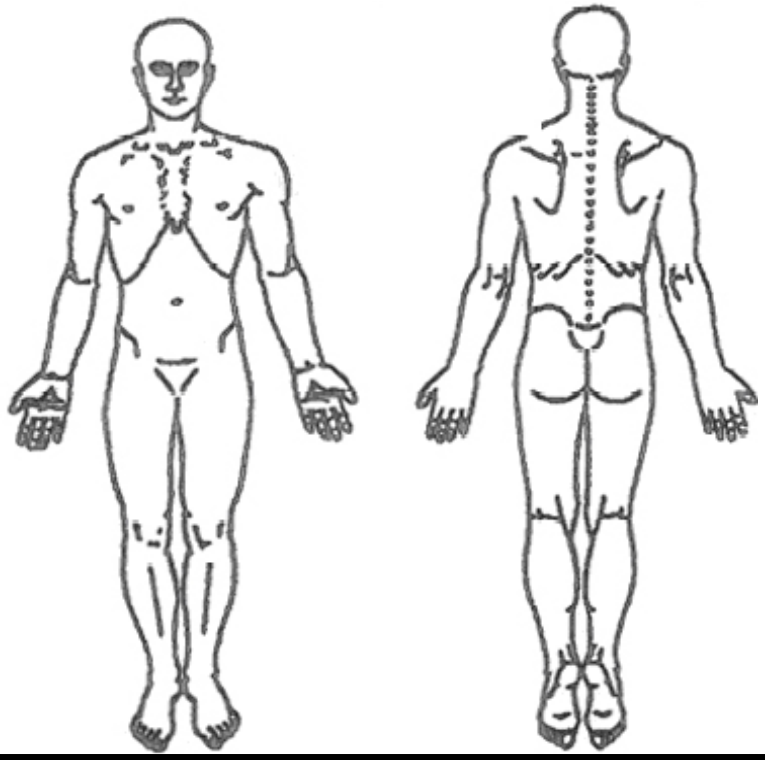
Signature of Patient, Parent, Guardian, or Personal Representative:	**Date:**

PAIN AND SYMPTOM STATUS FORM

Patient Name: _____ **Date:** _____

PLEASE DRAW ON THE BODY THE TYPE OF PAIN YOU ARE EXPERIENCING USING THE SYMBOLS BELOW.

Deep Aching	Pins & Needles	Numbness
M M M M	□ □ □ □ □ □ □ □	O O O O O O
M M M	□ □ □ □ □ □	O O O O
Burning	**Stabbing**	**Other**
---- ---- ----	/ / / / / / /	x x x x x
---- ----	/ / / / /	x x x x



CHIEF COMPLAINT AND NUMBERICAL PAIN SCALE

MY CHIEF COMPLAINT IS: _____

START DATE OF INJURY/SYMPTOMS: _____

2ND COMPLAINT: _____

3RD COMPLAINT: _____

Please circle your **CURRENT** level of pain on the scale below:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Please circle your **AVERAGE** level of pain on the scale below:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Please circle your **WORST** level of pain on the scale below:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Additional Comments: _____

_____

_____

Signature of Patient, Parent, Guardian, or Personal Representative:	Date:

Patient Consent Form

MEDICAL RELEASE OF INFORMATION

By signing this form, you are granting consent to Debbie Fontenot Physical Therapy & Wellness, APMC to request, use and disclose your protected health information for the purpose of treatment, payment, and health care operations. Our Notice of Privacy Practice (Federal Register, 45 CFR 164.520) provides more detailed information about you.

You have the right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required to agree to this restriction. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent, in writing, except where we have already made disclosers in reliance on your prior consent.

Circle any of the following diagnostic tests: MRI X-RAY CT SCAN OTHER

Where were these tests performed: _____

Recent Surgery: _____ Date: _____

Hospital: _____ Surgeon: _____

Patient /Legal Representative: _____

Today's Date: **Date Of Birth:** _____