



CONFIDENTIAL MEDICAL HISTORY/ EVALUATION

NAME: _____ DATE: ___/___/___ REFERRING MD: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: ___/___/___ SS #: _____ PHONE #: _____ WK #: _____

INSURANCE COMPANY: _____ SUBSCRIBE ID: _____ GROUP: _____

INSURED EMPLOYER/ ADDRESS: _____ PHONE: _____

OCCUPATION: _____ CHIEF COMPLAINT: _____

DATE OF INJURY: _____ CURRENT SYMPTOMS: (CIRCLE) PAIN NUMBNESS STIFFNESS

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING OVER THE COUNTER: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS: _____

LIST ANY SURGERIES: _____

HAVE YOU HAD ANY DIAGNOSTIC SERVICES FOR THE INJURY? (CIRCLE) MRI X RAYS OTHER

DO YOU HAVE ANY OF THE FOLLOWING?

	YES	NO		MILD	MODERATE	SEVERE
ASTHMA, BRONCHITIS OR EMPHYSEMA	_____	_____	BENDING	_____	_____	_____
SHORNESS OF BREATH/CHEST PAIN	_____	_____	CARE FOR FAMILY	_____	_____	_____
CORONARY HEART DISEASE	_____	_____	CARRYING GROCERIES	_____	_____	_____
DO YOU HAVE A PACEMAKER	_____	_____	CHANGE POS	_____	_____	_____
HIGH BLOOD PRESSURE	_____	_____	CLIMB STAIRS	_____	_____	_____
HEART ATTACK/ SURGERY	_____	_____	DRIVING	_____	_____	_____
STROKE/TIA	_____	_____	EXTENDED COMP USE	_____	_____	_____
BLOOD CLOT/EMBOLI	_____	_____	FEEDING (SELF)	_____	_____	_____
EPILEPSY/SEIZURES	_____	_____	HOUSEHOLD CHORES	_____	_____	_____
THYROID TROUBLE/GOITER	_____	_____	KNEELING	_____	_____	_____
ANEMIA	_____	_____	LIFTING CHILDRES	_____	_____	_____
INFECTIOUS DISEASE	_____	_____	LIFTING	_____	_____	_____
DIABETES	_____	_____	PET CARE	_____	_____	_____
CANCER OR CHEMO/RADIATION	_____	_____	READING	_____	_____	_____
ARTHRITIS/SWOLLEN JOINTS	_____	_____	SELF CARE (BATHING)	_____	_____	_____
OSTEOPOROSIS	_____	_____	SELF CARE (DRESSING)	_____	_____	_____
VARICOSE VEINS	_____	_____	SELF CARE (SHAVING)	_____	_____	_____
GOUT	_____	_____	SEXUAL ACTIVITES	_____	_____	_____
SLEEPING DIFFICULTIES	_____	_____	SLEEP	_____	_____	_____
EMOTIONAL/ PSYCHOLOGICAL PROBLEMS	_____	_____	SITTING (PROLONGED)	_____	_____	_____
BOWEL OR BLADDER PROBLEMS	_____	_____	STANDING (PROLONGED)	_____	_____	_____
SEVERE/ FREQUENT HEADACHES	_____	_____	WALKING	_____	_____	_____
VISION/HEARING DIFFICULTIES	_____	_____	YARD WORK	_____	_____	_____
DIZZINESS OR FAINTNESS	_____	_____	SPORTS	_____	_____	_____
ARE YOU PREGNANT?	_____	_____	RECREATIONAL ACT.	_____	_____	_____
DO YOU SMOKE?	_____	_____	DO YOU EXERCISE? DAILY _____ WEEKLY _____			
ALCOHOL CONSUMPTION DAILY _____ WEEKLY _____			OTHER MEDICAL CONDITIONS: _____			

ARE YOU AWARE OF YOUR DIAGNOSIS? YES ___ NO ___ ARE YOU AWARE OF YOUR PROGNOSIS? YES ___ NO ___
I HEREBY AGREE AND GIVE MY CONSENT TO MEDICAL TREATMENT IN TREATING MY PHYSICAL CONDITION. I AUTHORIZE
RELEASE OF ANY MEDICAL INFORMATION NEEDED TO PROCESS MY CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR
ANY CHARGES THAT ARE NOT COVERED BY MY INSURANCE CARRIER. FURTHERMORE, I UNDERSTAND THAT I AM
RESPONSIBLE TO INFORM THE OFFICE OF ANY CHANGES THAT OCCUR WITH MY INSURANCE. I AUTHORIZE RELEASE OF
PAYMENT DIRECTLY TO AVANTE PHYSICAL THERAPY REGARDLESS OF PARTICIPATION IN OR OUT OF NETWORK. SHOULD I
DEFAULT ON MY FINANCIAL RESPONSIBLTY AND COLLECTION ACTION IS NECESSARY, I WILL BE RESPONSIBLE FOR
COLLECTION COSTS THAT ARE INCURRED.

PATIENT/PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

I ACKNOWLEDGE THAT I HAVE SEEN THE "NOTICE TO PRIVACY PRACTICES." I UNDERSTAND THAT I MAY ASK QUESTIONS
ABOUT THE "NOTICE OF PRIVACY PRACTICES" AT ANY TIME.
PATIENT/PARENT/GUARDIAN SIGNATURE: _____ DATE: _____