FREDERICKSBURG ORTHOPAEDIC ASSOCIATES, P.C.
PHYSICAL THERAPY INSTITUTE

PATIENT MEDICAL HISTORY FORM

After completing this form, print and sign at the bottom; and, provide to the receptionist when you check in.

PLEASE ANSWER THE FOLLOWING QUESTIONS COMPLETELY

1. Check all that apply and explain the following medical problems that you have had:

☐ AIDS / HIV	☐ Drug Abuse	☐ Liver Disease
☐ Allergies	☐ Emphysema	☐ Motor Vehicle Accident
☐ Anemia	☐ Fainting	☐ Psychiatric Treatment
☐ Arthritis	☐ Fractures	☐ Rheumatic Heart Disease
☐ Asthma	☐ Glaucoma	☐ Seizures
☐ Back Trouble	☐ Heart Disease	☐ Shortness of Breath
☐ Bronchitis	☐ Heart Attack	☐ Sinusitis
☐ Cancer	☐ Heart Murmur	☐ Stomach Ulcers
☐ Chest Pain	☐ Hepatitis	☐ Stroke
☐ Congenital Heart Defect	☐ Herpes	☐ Swelling of Hands / Feet
☐ Convulsions	☐ High Blood Pressure	☐ Thyroid Disease
☐ Diabetes	☐ Kidney Disease	☐ Rheumatic Fever
☐ Bleeding Disease	☐ Osteoporosis	☐ Osteopenia

2. List any operation or surgery that you have had:

3. Reasons for being referred to Physical Therapy:

4. List any medication you are currently taking:

5. List any allergies and describe any drug reactions:

6. Please check any of the following you may have / wear:

☐ Glasses ☐ Contacts ☐ Dentures ☐ Pacemaker ☐ Metal Foreign Object Implant

7. Are you pregnant? ☐ Yes ☐ No

8. Any significant weight gain / loss in the last year? ☐ Yes ☐ No (±) _____lbs

9. Are you under the care of any other medical/health provider or physician? ☐ Yes ☐ No
   If Yes, for what condition are you being treated? _____

10. What do you expect to gain/accomplish in receiving physical therapy?

_____

TO THE BEST OF MY KNOWLEDGE, INFORMATION PROVIDED HEREIN IS CORRECT.

Signature:_____ Date:_____

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PHYSICAL THERAPY TREATMENT POLICY

The following is a brief explanation of our policies regarding physical therapy treatments.

THIS PHYSICAL THERAPY DEPARTMENT IS PART OF FREDERICKSBURG ORTHOPAEDIC ASSOCIATES, P.C. IF YOU CHOOSE TO HAVE YOUR PHYSICAL THERAPY PERFORMED AT ANOTHER FACILITY, WE WILL BE GLAD TO REFER YOU.

An itemized list of charges for your treatment will be given to you on your first visit to the therapy department. Payment in full will be expected at the time of each visit unless proof of full or partial insurance coverage for physical therapy has been furnished. If you have partial insurance coverage, you will be expected to pay the non-covered amount. If you cannot do this, arrangements must be made with our collection manager.

In most cases, we will file your insurance for you or assist you with it. Please discuss this with our receptionist.

We request notification of 24 hours prior to your appointment should you need to cancel. This allows us the opportunity to schedule another patient.

If you have any questions or concerns, please discuss them with us so we can better serve you.

I have read and understand the above policies.

SIGNED:_____

DATE:_____