Moab Physical Therapy and Rehabilitation
83 E Center St. Moab, Utah 84532 Phone: 435-210-1985

MOAB PHYSICAL THERAPY & REHABILITATION

RETURN PATIENT: PERSONAL INFORMATION

PLEASE COMPLETE ALL SECTIONS that have CHANGED since last treatment:		
Full Legal Name	Home Phone	Cell Phone
Address	City	Zip Code
Email address (print clearly)	**Date of Birth:** _____ / _____ / _____	Last 4 digits (only) social security -___ ___ ___ ___
**Preferred appointment notification: ___ EMAIL ___ TEXT ___Phone call	Marital Status __single __married __divorced __widowed __separated	
Employer	Work phone	__ Full time __ part time __ unemployed __ retired
Other employment	Work phone	__ Full time __ part time
Primary Physician:	**Referring** Physician:	Physician phone
**** Emergency contact:** Name	**Emergency** Phone #	**Relationship**
IF NOT PRIMARY policy holder on your insurance plan: Provide full Name	Date of Birth of primary insured party: ___ / ___ / _____	

I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of my account for any professional services rendered. I am also responsible for recognizing insurance status including, but not limited to, benefits and allowable visits. I have read all the information on this page and certify that the information I provided is true and correct to the best of my knowledge. I also agree to notify Moab Physical Therapy and Rehabilitation of any changes in the above information.

Signature: _____ Date: _____
Parent or Guardian (if minor): _____ Date: _____

CONSENT FOR TREATMENT:
I hereby give permission for Moab Physical Therapy and Rehabilitation to render treatment to myself. I understand that I will be given all available pertinent information prior to the treatment being rendered. I will be given the opportunity to ask questions and to have them answered to my satisfaction. I understand that I may decline treatment at any time.

Signature: _____ Date: _____

CONSENT TO RELEASE / OBTAIN MEDICAL INFORMATION:
Permission is herby granted to Moab Physical Therapy and Rehabilitation to release information to my insurance company, employer, attorney, workers compensation carrier, and physician or facility referred to for further treatment and/or my referring primary care physician. Permission is herby granted to any facility where I have been treated to release medical records to Moab Physical Therapy and Rehabilitation.

Signature: _____ Date: _____

HIPAA Privacy and Disclosure Notice Reminder
I was informed that my personal and medical information will not be shared without proper authorization:

Initial

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MEDICAL HISTORY

PLEASE COMPLETE ALL SECTIONS		
Mechanism of Injury:	Injury Date: Have you had: XRAY / MRI / CT scan / other	Surgery : YES / NO Date: _____
Have you had physical or occupational therapy this year? YES / NO How did you hear about us?		How many visits?
Are you under going, or undergone any treatment for this injury? MD / Chiro / PT / Massage / Other Please Explain:		
Has your primary care physician ever warned you against exercise? YES / NO Please Explain:		
Are you currently engaged in some form of exercise? YES / NO Please Explain:	Do you currently have restrictions at work due to injury or currently unable to work? YES / NO Please Explain:	
Have you ever been diagnosed by a physician with any of the following: □ History of Cancer □ Diabetes □ Fibromyalgia □ Osteoporosis □ Cardiac Disease □ Arthritis □ High Blood Pressure □ Respiratory Disease □ Chronic Fatigue □ Epilepsy □ Myofascial pain □ OTHER: _____		
Have you experienced any of the following symptoms in the past few weeks to 1 month: □ Abdominal or Chest Pain □ Dizziness or Fainting □ Nervousness □ Frequent Urination □ Unexplained Weight Loss □ Illness or Fever □ Severe Fatigue □ Loss of Balance □ Irregular Heart Beat □ Migraines/ Headache □ Depression □ Shortness of Breath		
Are you pregnant? YES / NO	Please list any **medical** conditions not mentioned above:	

Please list **all** current prescription **medications:**

list **all** herbal supplements (Vitamin D, etc):

list **all** over the counter medications (Aspirin, Advil, etc):

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____ _____ _____

SIGNATURE DATE PLEASE PRINT NAME