Freedom Physical Therapy & Fitness
5310 Acton Highway, Suite 106
Granbury, TX 76049
Phone 817-326-1375 Fax 817-326-2068

Patient Information

Name:_____ Date of Birth:_____

Cell Phone:_____ Home Phone: _____

Work Phone:_____ Sex (optional): M F

Marital Status: Married Single Divorced Widow(er)

Email: _____

Address: _____

City/State/Zip: _____

Employer: _____

Emergency Contact/Phone: _____

Preferred way to receive calls: Cell Home Work Other:_____

If your insurance is with TRICARE:

Name of Primary Insured:	
SSN:	DOB:

I understand that I am being treated by licensed personnel and I do give my consent to receive this care.I hereby authorize Freedom Physical Therapy to receive the payment directly for the medical benefits payable to me under the terms of my insurance.

Patient or Guardian Signature: _____

I understand that, as a courtesy, this office will file my insurance. I understand that quoted benefits are an estimate of final payment from my insurance and that the final balance is my responsibility. I understand that my ESTIMATED co-pay or co-percentage due at each visit is_____.

Patient or Guardian Signature: _____

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MEDICAL HISTORY FORM

Patient Name:_____ **Date**:_____

Referring Physician:_____Family Physician:_____

Do you have any of the following conditions (circle those that apply): Diabetes Type 1 Diabetes type 2

High Blood Pressure Cardiovascular Disease Pulmonary Disease History of Cancer

Do you have other medical history we should know about?:

_____

Have you had a surgery/surgeries in the past year? YES NO

If yes, please explain:_____

What is your goal in therapy? _____

When did your current symptoms begin?_____

What caused your current symptoms to begin?_____

Please list your current medications:

Name of Medication	Dosage	Purpose	When Taken

Please rate your pain on a 0 to 10 scale, with 0 = no pain, and 10 = emergency room pain:

Current pain on scale from 0 to 10: 0 – 1 – 2- 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Worst pain on scale from 0 to 10: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Least pain on scale from 0 to 10: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

I certify that this information is complete and correct: _____

(Patient Signature)

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Acknowledgment of Receipt of Notice of Privacy Practices

Freedom Physical Therapy reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for Freedom Physical Therapy:

_____

Name of Patient (print)

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative (required if patient is a minor or an adult who is unable to sign this form.)

_____

Relationship of Patient Representative to Patient