



Label & Associates
physical therapy

Confidential Medical Information

Please state current problem(s): _____

Are you currently being treated by:

Another Therapist _____ Yes _____ No Or in the past _____ Yes _____ No
Chiropractor _____ Yes _____ No Or in the past _____ Yes _____ No
Home Health Agency _____ Yes _____ No Or in the past _____ Yes _____ No

Major surgeries since birth: _____

Allergies: _____

List current medications: _____

Check if you currently have or previously had any of the following

- | | |
|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Other Illnesses |

Specify: _____

Specify: _____

Is injury a result of an Auto Accident <input type="checkbox"/> Yes <input type="checkbox"/> No	Work Related <input type="checkbox"/> Yes <input type="checkbox"/> No
Insurance Co. _____	Claim # _____
Case manager _____	Phone _____ - _____ - _____
Lawyer _____	Phone _____ - _____ - _____

The above information is true and accurate to the best of my knowledge. I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignment of benefits.

Signature _____ **Date** _____