Patient Name: _____ Date of Birth: _____

Returning Patient Questionnaire

1. Has any of the following information changed? **YES / NO** (If yes, Please fill out all applicable sections so we may update your file. If your insurance has changed, it is YOUR responsibility to provide the new cards upon arrival at the first visit.)

- Insurance: _____
- Medical condition(s): _____

  _____
- Name: _____
- Address: _____
- Phone #'s: _____
- E-mail address: _____
- Employer/occupation: _____

Explain: _____

_____

_____

2. Have you had physical therapy, chiropractic, occupational, psychological, speech or any other type of therapy this year? **YES / NO** (circle)

If yes, approximately how many visits? _____

Patient signature _____ Date _____

Made to Move Physical Therapy, Inc.
615 N Nash St., Ste # 306
El Segundo, CA 90245
310.535.0008

Patient Name:_____ ***Date of Birth:_____***

Assignment of Benefits: ***(MUST BE SIGNED IN ORDER TO BILL YOUR INSURANCE FOR SERVICES PROVIDED)***
I hereby assign payment directly to Made to Move Physical Therapy, Inc. who represents this clinic to Payor Groups for the basic benefits, as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this treatment period. I understand that if this is a motor vehicle accident and the medical benefits are exhausted, financial responsibility reverts to my health insurance. I am financially responsible for any applicable deductibles, co-insurances, or co-pays. I also understand that I am financially responsible for any charges not covered by this assignment. I understand I will be held responsible for any costs incurred regarding collection of payment for services rendered. I will update billing information in writing to Made to Move Physical Therapy, Inc. as soon as any changes occur in my insurance coverage or address.

Signature X_____ Date_____

Relationship to Patient_____

Consent to Share Medical and/or Billing Information
In the event that our staff may need to discuss medical or billing issues with you or your family, ***please provide the name(s)*** of those with whom we may speak. This allows us to maintain your privacy. Thank you.

Medicare Insurance **(ONLY COMPLETE IF YOU HAVE MEDICARE AS YOUR HEALTH INSURANCE)**
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Made to Move Physical Therapy, Inc. for any services furnished to me by that provider. I authorize any custodian of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Medicare Supplemental Insurance
I herby give Made to Move Physical Therapy, Inc. permission to bill for Medicare Supplemental Insurance payments for my medical care. I understand that my supplemental insurance may need information about me and my medical condition to make a decision about these payments. I give permission for that information to go to my supplemental insurance carrier. I request that payment of authorized Medicare Supplemental benefits be made either to me or on my behalf to Made to Move Physical Therapy, Inc. for any services furnished me by that provider.

I understand and agree to all of the above.

Signature X_____Date_____

Relationship to Patient_____

PATIENT MEDICAL HISTORY

Please completely fill out the following questions. This will assist us in properly treating you and identifying possible contraindications for certain treatments. All information is held in strict confidence.

Name: _____ **B**irthdate:_____

Date of Injury / Surgery or Onset of Complaint(s):_____
(Please Give Approximate Date if Not Sure)

Where were you injured? Work____ Home____ Other____

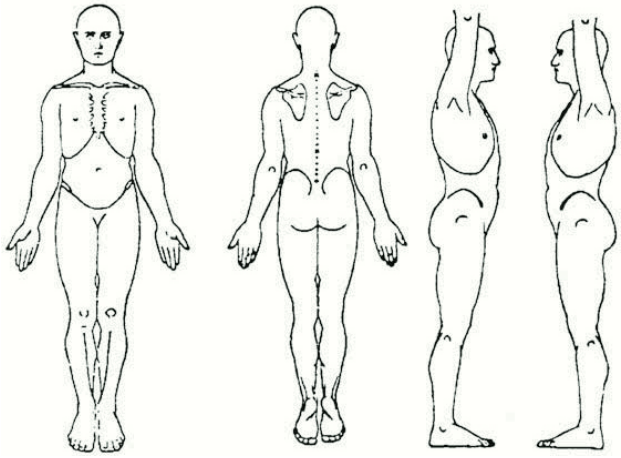
Briefly describe how you were injured or how complaints began (i.e. after gardening,

lifting….):_____

_____

Where is your pain/injury located? _____

Please use the drawings to indicate the location of your pain/injury.



List all over-the-counter and prescription medications you are currently taking for any reason: (include pills,

injections skin patch, etc.) _____

_____

_____

If you have any metal or other implants in your body, please describe where they are:_____

_____

Have you had any treatment for this condition? Yes____ No____

If yes, please describe: _____

Please mark any of the following diagnostic studies completed for this condition:

____X-Rays ____Electromyograph (EMG) ____MRI ____ Computed Tomagraphy (CT Scan)

____Other: _____

Have you ever been diagnosed with any of the following? (Please circle)

HEART DISEASE

Congestive heart failure (CHF)	Pacemaker	Heart attack (Myocardial infarction)
Atherosclerotic disease (CAD)	Angioplasty	Valvular disease
Stents	Arrhythmia	Coronary artery bypass graft (CABG)
Angina	Other:	

LUNG DISEASE

Asthma	Emphysema	Chronic obstructive pulmonary disease (COPD)
Recent pneumonia	Other:	

VASCULAR DISEASE

Peripheral arterial disease	Stroke / TIA	Acquired respiratory distress syndrome (ARDS)
Chronic bronchitis	Diabetes	Hypertension (high blood pressure)
Taking blood pressure meds	Other:	Deep Vein Thrombosis (blood clot)

GENERAL MEDICAL CONDITIONS

Osteoporosis / Osteopenia	Allergies	Arthritis (Rheumatoid / Osteoarthritis)
Anxiety or panic disorders	Depression	Other emotional / psychological problems
Headaches	Previous accidents	Incontinence / Urination problems
Hearing impairment	Sleep dysfunction	Kidney / Bladder / Prostrate problems
Hepatitis / HIV / AIDS	Prosthesis / Implants	Prior surgery(s)
Cancer	Anemia	Epilepsy
Pregnant, or think you might be.	Tuberculosis	Thyroid Problems
Headaches	Neurological Disease (e.g. MS, parkinson's)	
Gastrointestinal disease (e.g. ulcer, hernia, reflux, bowel, liver, gall bladder)		
Other Arthritic Conditions	Other:	

Please list any surgeries or other conditions for which you have been hospitalized.

Date Surgery/Hospitalization Reason:

_____

_____

_____

_____

Do you smoke tobacco? Yes ____ No ____ If Yes, how much per day? _____

What are your goals for physical therapy? _____

_____

_____

X_____ _____

Patient's signature **Date**

(NOTE: Insurance carriers require a signature)