

**FOOTHILLS PHYSICAL THERAPY  
PATIENT HISTORY**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ SS#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Email Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

.....  
Have you previously had physical therapy?    Yes    No    When? \_\_\_\_\_

Are you currently receiving any type of VNA Services?    Yes    No

Was it for the same problem that you are currently seeking treatment?    Yes    No

.....  
Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

.....  
**PLEASE COMPLETE:**    Name of Insurance to Bill: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**ID/Claim#:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Health Insurance Subscriber: (circle one)    Self    Spouse    Parent**

If other than self:    Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**If Injury is related to work or an auto accident - DATE OF INJURY** \_\_\_\_\_

**PLEASE CIRCLE if applicable: AUTO: YES/NO** State of accident \_\_\_\_\_ **WORKERS COMP: YES/NO**

Adjuster: \_\_\_\_\_ Phone #: \_\_\_\_\_

**PRIVACY NOTICE**

We here at Foothills Physical Therapy feel that your privacy should be protected. In the course of your treatment, we collect person information about you that is necessary to treating you. As our valued patient, we treat this information as confidential and recognize the importance of protecting it. A copy of our complete HIPPA Notice of Privacy Practices is available upon request. By signing below, I acknowledge that I have been permitted to access and/or have a copy of this information.

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient at Foothills Physical Therapy.

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_