7431 W. Atlantic Ave, Ste. 52
Delray Beach, FL 33446

BACK IN ACTION
PHYSICAL THERAPY

ph. (561) 638-7455
fax (561) 638-7873

Indicates required information for insurance processing.

*Patient Name:_____ Today's Date:___/___/___ *SSN_____
*Street Address:_____ Apt/Unit#:_____ *DOB___/___/___
*City:_____ *State:_____ *Zip:_____ ◯ Male ◯ Female
Home Phone:_____ Cell/Other Phone:_____
Email Address:_____
Occupation:_____ Employer:_____
Emergency Contact:_____ Relationship to Patient:_____
Emergency Contact Number:_____
Family Physician:_____ Physician Phone:_____

Have you ever been seen in our office as a patient before this visit? Yes or No If Yes, date of last visit:_____

In the event that we have to contact you, may we leave a message on your answering machine? Yes or No

Is this a Worker's Compensation Claim? Yes or No If yes, date of injury:_____ Claim#_____
Company Name:_____ Address:_____
Phone:_____ Contact Person:_____

Is this an Accident case? Yes or No ◯ Vehicle ◯ Other:_____ Date of Accident:_____
Insurance Company to Bill:_____ Adjuster Name:_____
Address:_____
Phone:_____ Claim#:_____
Is there pending litigation concerning your injury? Yes or No If yes, attorney name:_____
Attorney Address:_____ Attorney Phone:_____

How did you hear about Back In Action Physical Therapy?
◯ Friend ◯ Physician ◯ Yellow Pages ◯ Web site ◯ Other:_____
Referring Doctor Name and Phone:_____ Referring Friend Name:_____

I consent to BKR Therapies, Inc. dba Back in Action. for treatments/procedures that are necessary or advisable for my care. I hereby grant authorization to BKR Therapies, Inc. dba Back in Action to exchange with and/or release requested information on my medical care to my insurance carrier(s) and to:

◯ Patient/Guardian ◯ Worker's Compensation Attorney ◯ Rehabilitation Intermediary

I certify that the information furnished by me is correct and hereby direct and authorize payment of health care benefits due me by insurer to BKR Therapies, Inc. dba Back in Action. I understand that I am financially responsible for payment of fees regardless of insurance coverage. I also certify that I have received the initial patient information from BKR Therapies, Inc. dba Back in Action.
Print Name:_____ **Signature:**_____ **Date:**_____

A copy of BKR Therapies Inc., dba Back In Action's Privacy Notice is posted near the front reception window. I understand that I may obtain a personal copy of the Privacy Notice by requesting one from the Front Reception Coordinator.
Signature:_____ **Date:**_____

Responsible party's name and signature, if patient is a minor:_____

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Patient Health History Form 1

Who do you live with? (circle one) Alone Spouse Only Spouse and Other(s) Child
Other Relative Group Setting Personal Care Attendant Other:

Has anyone in your immediate family (parents, brother, sisters) been treated for any of the following?

Diabetes	No Yes	Headaches	No Yes
Stroke	No Yes	Epilepsy	No Yes
Kidney Disease	No Yes	Mental Illness	No Yes
Alcoholism	No Yes	Cancer	No Yes
Tuberculosis	No Yes	Arthritis	No Yes
Heart Disease	No Yes	Anemia	No Yes
High Blood Pressure	No Yes		

Have you ever been diagnosed with any of these conditions or have you recently experienced any of the following?
Please check all that apply.

◯ Allergies	◯ Fatigue	◯ Pace Maker
◯ Anemia	◯ Fever/Sweats/Chills	◯ Parkinson's Disease
◯ Anxiety	◯ Gall Bladder Problems	◯ Polio
◯ Arthritic Conditions (not RA)	◯ Hearing Problems	◯ Rheumatoid Arthritis
◯ Asthma	◯ Heart Attack/Heart Conditions	◯ Seizures/Epilepsy
◯ Cancer	◯ Hepatitis	◯ Speaking Problems
◯ Chemical Dependency (Alcoholism)	◯ High Blood Pressure	◯ Stroke
◯ Circulation Problems	◯ Incontinence/Bowel Problems	◯ Thyroid Problems
◯ Currently Pregnant	◯ Kidney Disease	◯ Tuberculosis
◯ Depression	◯ Metal Implants	◯ Vision Impairment
◯ Diabetes	◯ Multiple Sclerosis	◯ Weakness
◯ Dizziness/Light headed	◯ Nausea/Vomiting	◯ Weight Gain
◯ Emphysema/Bronchitis	◯ Numbness/Tingling	◯ Weight Loss
◯ Fractures	◯ Osteoporosis/Osteopenia	◯ Other:_____

At the present time, would you say your health is: ◯ Excellent ◯ Very Good ◯ Fair ◯ Poor
Do you ever feel unsafe at home or has anyone hit or injured you in any way? Yes or No
How much caffeinated or caffeine containing beverages do you drink per day? _____
Do you smoke cigarettes? Yes or No If Yes, how many per day? _____
Do you drink alcohol? Yes or No If Yes, how many drinks per day/week? _____
Do you perform regular exercise? Yes or No If Yes, how often? _____
Please list any allergies. _____

Which of the following over-the-counter medications have you taken in the last week? ***Please check all that apply.***
◯ Aspirin ◯ Tylenol ◯ Advil/Motrin/Ibuprofen Laxatives ◯ Antihistamines ◯ Antacids
◯ Decongestants ◯ Vitamins/Mineral Supplements ◯ Other: _____

Please list all Vitamins/Supplements you are currently taking: _____
Please list all Prescriptions you are currently taking: _____
_____
_____

Do any of your medications cause you to be dizzy or lose your balance? Yes or No

Print Name: _____ **Signature:** _____ **Date:** _____

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Patient Health History Form 2

Height: _____ Weight: _____

Have you ever been hospitalized and/or had major surgery? Yes No
If Yes, please provide details: _____

Your Current Condition

Where or how did your injury/symptoms occur? ◯ Recreation ◯ Home ◯ Auto Accident ◯ Work ◯ Unknown ◯ Other: _____

What activities are limited by your injury (ie lifting, standing, etc.)? _____

For this injury, please check all medical care that you have received thus far.

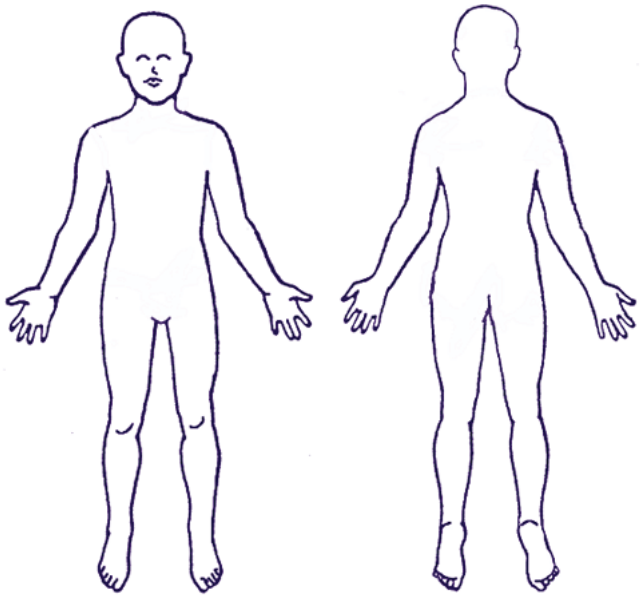
◯ Surgery When? _____ What kind? _____
◯ Injection When? _____ Where? _____ Did it help? _____
◯ Prior physical therapy When? _____ What was done? _____
◯ Home Health When? _____
◯ Chiropractor When? _____ What was done? _____
◯ X-Ray ◯ MRI ◯ CT Scan ◯ NCV (Nerve Conduction Velocity) ◯ Other:
◯ Exercises: _____

Are your symptoms: ◯ Constant? ◯ Intermittent? ◯ Getting better? ◯ Getting worse? ◯ No change?

Please rate your major area of pain on the 0 – 10 Pain Rating Scale by circling the number of your pain where 0 is "no pain" and 10 is "unbearable pain."

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

Please indicate where on the body you are having pain.



Print Name: _____ **Signature:** _____ **Date:** _____