Cris A. Walters, MPT
512 Main St, Ashton, ID 83420

## Patient Information

Name_____
Address _____
City _____State____ZIP_____
Date of Birth (mm/dd/yyyy) _____
Sex □ M □ F
Home Phone _____
Cell Phone _____
Work Phone _____
Employer _____
Address _____
City _____ State ____ ZIP_____

Referring Physician_____
City _____ State ____ ZIP _____
Phone Number _____

Is this accident-related? □ Yes □ No
Date of accident_____
Is it Work Comp? □ Yes □ No
Is it the result of an automobile accident?
□ Yes □ No
Did the accident happen in Idaho? □ Yes □ No
If not, where did it occur? _____

## Insurance Information

Primary _____
Address _____
City _____ State ___ ZIP _____
Subscriber's Name _____
Relationship to Patient _____
Subscriber's DOB (mm/dd/yyyy) _____
ID Number_____
Group Number _____

Secondary _____
Address _____
City _____ State ____ ZIP _____
Subscriber's Name _____
Relationship to Patient _____
Subscriber's DOB (mm/dd/yyyy) _____
ID Number _____
Group Number _____

## Additional Information

Spouse's Name (if married) _____
Employer _____
Work Phone _____

Emergency contact not living with you:
Name_____
Phone _____

I authorize Alpine Physical Therapy to release medical records to designated insurance companies to facilitate payment of authorized benefits. Under all circumstances, I assume final financial responsibility for my account. I consent to physical therapy services prescribed by any physician. I authorize payment of medical benefits by my insurance company to Alpine Physical Therapy for services rendered.

Date _____ Signature_____

ALPINE
PHYSICAL THERAPY

## Worker's Compensation Information

Date of Injury _____
Employer _____
Address _____
Phone _____

Is this State Insurance Fund? □ Yes □ No
If not, what? _____
Claim Number _____
SSN _____--_____--_____

## Medicare Authorization Signature

I request that payment of authorized Medicare benefits be made on my behalf to Alpine Physical Therapy, PLLC, for any services furnished by them. I authorize any holder of medical information about me to release to Alpine Physical Therapy and the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature _____ Date_____

Are you currently being/have you in the past 30 days been treated under a Home Health Episode?
□ Yes □ No

## Information Needed for Treatment of a Minor

Father's Name _____
Address _____
City _____ State ___ ZIP _____
Employer _____
Work Phone _____

Mother's Name _____
Address _____
City _____ State ____ ZIP _____
Employer _____
Work Phone _____

ALPINE
PHYSICAL THERAPY

Cris A. Walters, MPT

## Patient History

Name _____ Date _____

What is your problem or injury? _____

How did your problem or injury begin? _____

How long ago did it begin? _____

What is your type of work? _____

Are you working? □ Yes □ No If no, is it because of your injury? □ Yes □ No

Before this injury, were you completely free of symptoms? □ Yes □ No

Have you ever had anything similar before? □ Yes □ No

What, if any, treatments have you had for this current problem?

□ Physical Therapy □ Chiropractic □ Medical □ Other

What eases your pain?

□ Sitting □ Standing □ Walking □ Lying Down □ Other _____

What makes your pain worse?

□ Sitting □ Standing □ Walking □ Lying Down □ Other _____

Do you have any feelings of pins and needles or numbness? □ Yes □ No

Do you have any other problems? □ Yes □ No

If yes, explain _____

Are you taking any medications? □ Yes □ No

Which? _____

Indicate on the body figure the places of discomfort.