Do you have high blood pressure?	Name:		Date:	
Do you have heart disease? Yes No Do you experience shortness of breath? Yes No Do you experience shortness of breath? Yes No Do you experience shortness of breath? Yes No Do you have lung disease? Yes No Do you have preme heartbum or upset stomach? Yes No Do you have a thyroid condition? Yes No Do you have a thyroid condition? Yes No Do you have a diabetes? Yes No Do you have diabetes? Yes No Do you have low bold sugar? Yes No Do you have on steeporosis? Yes No Do you have on steeporosis? Yes No Do you have on steeporosis? Yes No Do you have unusual joint pain and/or swelling? Yes No Do you have a history of factures? Yes No Do you have a pacemaker? Yes No Do you have a pacemaker? Yes No Do you have impaired implants? Yes No Do you have impaired hearing? Yes No Do you have impaired hearing? Yes No Any OTHER MEDICAL PROBLEMS? 4. ANY OTHER MEDICAL PROBLEMS? 5. PLEASE LIST ALL SURGERIES AND APPROXIMATE DATES: 6. PLEASE LIST ALL DIAGNOSTIC TESTS FOR YOUR CURRENT PROBLEMS: 7. HAVE YOU SEEN ANYONE ELSE FOR YOUR CURRENT PROBLEMS: We appreciate your completion of this questionnaire as it helps your therapist get a better understanding of you total health status. The questionnaire is a part of your confidential medical record and your therapist will answ any of your questions during your examination.	1.	MEDICAL HISTORY:		
Do you have heart disease? Yes No Do you experience shortness of breath? Yes No Do you experience shortness of breath? Yes No Do you experience shortness of breath? Yes No Do you have lung disease? Yes No Do you have preme heartbum or upset stomach? Yes No Do you have a thyroid condition? Yes No Do you have a thyroid condition? Yes No Do you have a diabetes? Yes No Do you have diabetes? Yes No Do you have low bold sugar? Yes No Do you have on steeporosis? Yes No Do you have on steeporosis? Yes No Do you have on steeporosis? Yes No Do you have unusual joint pain and/or swelling? Yes No Do you have a history of factures? Yes No Do you have a pacemaker? Yes No Do you have a pacemaker? Yes No Do you have impaired implants? Yes No Do you have impaired hearing? Yes No Do you have impaired hearing? Yes No Any OTHER MEDICAL PROBLEMS? 4. ANY OTHER MEDICAL PROBLEMS? 5. PLEASE LIST ALL SURGERIES AND APPROXIMATE DATES: 6. PLEASE LIST ALL DIAGNOSTIC TESTS FOR YOUR CURRENT PROBLEMS: 7. HAVE YOU SEEN ANYONE ELSE FOR YOUR CURRENT PROBLEMS: We appreciate your completion of this questionnaire as it helps your therapist get a better understanding of you total health status. The questionnaire is a part of your confidential medical record and your therapist will answ any of your questions during your examination.		Do you have high blood pressure?	Ves	No
Do you experience angina (chest pain)? Do you experience shortness of breath? Do you bave lung disease? Yes No Do you have lung disease? Yes No Do you bave lung disease? Yes No Do you have lung disease? Yes No Do you have during disease? Yes No Do you have a thyroid condition? Yes No Do you have diabetes? Yes No Do you have disease? Yes No Do you have disease? Yes No Do you have a history of cancer? Yes No Do you have a history of cancer? Yes No Do you have osteoporosis? Yes No Do you have a history of fractures? Yes No Do you have a nivery of fractures? Yes No Do you have a pacemaker? Yes No Do you have a pacemaker? Yes No Do you have a pacemaker? Yes No Do you have impaired hearing? Yes No Do you have impaired vision? Have you experienced an increase in frequency or intensity of headaches? Yes No Current Height: It in Weight: It is ANY OTHER MEDICAL PROBLEMS? ANY OTHER MEDICAL PROBLEMS? PLEASE LIST ALL MEDICATIONS AND PURPOSES: HAVE YOU SEEN ANYONE ELSE FOR YOUR CURRENT PROBLEMS: HAVE YOU SEEN ANYONE ELSE FOR YOUR CURRENT PROBLEMS: We appreciate your completion of this questionnaire as it helps your therapist get a better understanding of you total health status. The questionnaire is a part of your confidential medical record and your therapist will answany of your questions during your examination.		Do you have heart disease?		
Do you experience shortness of breath?		Do you experience angina (chest pain)?		
Do you have lung disease? Yes No Do you experience heartburn or upset stomach? Yes No Have you experience heartburn or upset stomach? Yes No Do you have a thyroid condition? Yes No Do you have dishetes? Yes No Do you have low blood sugar? Yes No Do you have well on blood sugar? Yes No Do you have on the context of cancer? Yes No Do you have on story of cancer? Yes No Do you have unsual joint pain and/or swelling? Yes No Do you have a history of fractures? Yes No Do you have a mistory of fractures? Yes No Do you have any metal implants? Yes No Do you have any metal implants? Yes No Do you have impaired hearing? Yes No Do you have impaired hearing? Yes No Do you have impaired hearing? Yes No Do you have impaired siston? Yes No Do you have impaired siston? Yes No Current Height: In Weight: Ibs 2. ANY OTHER MEDICAL PROBLEMS? 4. PLEASE LIST ALL MEDICATIONS AND PURPOSES: 6. PLEASE LIST ALL MEDICATIONS AND PURPOSES: 6. PLEASE LIST ALL DIAGNOSTIC TESTS FOR YOUR CURRENT PROBLEMS: 7. HAVE YOU SEEN ANYONE ELSE FOR YOUR CURRENT PROBLEMS: 6. PLEASE LIST ALL DIAGNOSTIC TESTS FOR YOUR CURRENT PROBLEMS: 6. PLEASE LIST ALL DIAGNOSTIC TESTS FOR YOUR CURRENT PROBLEMS: 7. HAVE YOU SEEN ANYONE ELSE FOR YOUR CURRENT PROBLEMS: 8. Out the process of the process		Do you experience shortness of breath?		
Do you experience hearburn or upset stomach?				
Have you experienced recent weight loss/gain? Yes No Do you have a thyroid condition? Yes No Do you have diabetes? Yes No Do you have osteoporosis? Yes No Do you have osteoporosis? Yes No Do you have on stall joint pain and/or swelling? Yes No Do you have any antal implants? Yes No Do you have any metal faring? Yes No Do you have a pacemaker? Yes No Do you have a price dearing? Yes No Have you experienced an increase in frequency or intensity of headaches? Yes No Current Height: ft in Weight: Ibs No Current Height: ft in Weight: Ibs No ANY OTHER MEDICAL PROBLEMS? 3. Are you now or do you have any reason to believe you may be pregnant? Yes No PLEASE LIST ALL MEDICATIONS AND PURPOSES: 6. PLEASE LIST ALL SURGERIES AND APPROXIMATE DATES: 6. PLEASE LIST ALL DIAGNOSTIC TESTS FOR YOUR CURRENT PROBLEMS: 7. HAVE YOU SEEN ANYONE ELSE FOR YOUR CURRENT PROBLEMS: 6. PLEASE LIST ALL DIAGNOSTIC TESTS FOR YOUR CURRENT PROBLEMS: 6. PLEASE LIST ALL DIAGNOSTIC TESTS FOR YOUR CURRENT PROBLEMS: 7. HAVE YOU SEEN ANYONE ELSE FOR YOUR CURRENT PROBLEMS: 8. No Date of the properties of the prop				
Do you have a thyroid condition? Yes No Do you have diabetes? No Do you have diabetes? Yes No Do you have love blood sugar? Yes No Do you have a history of cancer? Yes No Do you have a history of cancer? Yes No Do you have unusual joint pain and/or swelling? Yes No Do you have a history of fractures? Yes No Do you have a history of fractures? Yes No Do you have a pacemaker? Yes No Do you have any metal implants? Yes No Do you have a pacemaker? Yes No Do you have impaired hearing? Yes No Do you have impaired hearing? Yes No Have you experienced an increase in frequency or intensity of headaches? Yes No Current Height: fin Weight: Ibs 2. ANY OTHER MEDICAL PROBLEMS? 3. Are you now or do you have any reason to believe you may be pregnant? Yes No 4. PLEASE LIST ALL MEDICATIONS AND PURPOSES: 5. PLEASE LIST ALL SURGERIES AND APPROXIMATE DATES: 6. PLEASE LIST ALL SURGERIES AND APPROXIMATE DATES: 6. PLEASE LIST ALL DIAGNOSTIC TESTS FOR YOUR CURRENT PROBLEMS: 7. HAVE YOU SEEN ANYONE ELSE FOR YOUR CURRENT PROBLEMS: We appreciate your completion of this questionnaire as it helps your therapist get a better understanding of you total health status. The questionnaire is a part of your confidential medical record and your therapist will answ any of your questions during your examination.				
Do you have loabetes? Yes No Do you have low blood sugar? Yes No Do you have a history of cancer? Yes No Do you have osteoporosis? Yes No Do you have usual joint pain and/or swelling? Yes No Do you have any metal implants? Yes No Do you have impaired hearing? Yes No Do you have impaired hearing? Yes No Do you have impaired vision? Yes No Current Height: It in Weight: Ibs 2. ANY OTHER MEDICAL PROBLEMS? 3. Are you now or do you have any reason to believe you may be pregnant? Yes No 4. PLEASE LIST ALL MEDICATIONS AND PURPOSES: 5. PLEASE LIST ALL SURGERIES AND APPROXIMATE DATES: 6. PLEASE LIST ALL DIAGNOSTIC TESTS FOR YOUR CURRENT PROBLEMS: 7. HAVE YOU SEEN ANYONE ELSE FOR YOUR CURRENT PROBLEMS: 6. PLEASE LIST ALL DIAGNOSTIC TESTS FOR YOUR CURRENT PROBLEMS: 7. HAVE YOU SEEN ANYONE ELSE FOR YOUR CURRENT PROBLEMS: 6. PLEASE LIST ALL DIAGNOSTIC TESTS FOR YOUR CURRENT PROBLEMS: 7. HAVE YOU SEEN ANYONE ELSE FOR YOUR CURRENT PROBLEMS: 8. OO OF THE PROBLEMS OF THE PROBLEM				
Do you have low blood sugar?				
Do you have a history of cancer?		Do you have low blood sugar?		
Do you have unusual joint pain and/or swelling?		Do you have a history of agree?		
Do you have unusual joint pain and/or swelling?		Do you have a fistory of cancer?		
Do you have a history of fractures? Yes No Do you have any metal implants? Yes No Do you have a pacemaker? Yes No Do you have impaired hearing? Yes No Do you have impaired vision? Yes No Have you experienced an increase in frequency or intensity of headaches? Yes No Current Height: In Weight: Ibs 2. ANY OTHER MEDICAL PROBLEMS? 3. Are you now or do you have any reason to believe you may be pregnant? Yes No PLEASE LIST ALL MEDICATIONS AND PURPOSES: 5. PLEASE LIST ALL SURGERIES AND APPROXIMATE DATES: 6. PLEASE LIST ALL DIAGNOSTIC TESTS FOR YOUR CURRENT PROBLEMS: 7. HAVE YOU SEEN ANYONE ELSE FOR YOUR CURRENT PROBLEMS: We appreciate your completion of this questionnaire as it helps your therapist get a better understanding of you total health status. The questionnaire is a part of your confidential medical record and your therapist will answany of your questions during your examination.				
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Do you have impaired vision? Yes No Have you experienced an increase in frequency or intensity of headaches? Yes No Current Height: ft in Weight: lbs 2. ANY OTHER MEDICAL PROBLEMS? lbs 3. Are you now or do you have any reason to believe you may be pregnant? Yes No PLEASE LIST ALL MEDICATIONS AND PURPOSES: 5. PLEASE LIST ALL SURGERIES AND APPROXIMATE DATES: 6. PLEASE LIST ALL DIAGNOSTIC TESTS FOR YOUR CURRENT PROBLEMS: 7. HAVE YOU SEEN ANYONE ELSE FOR YOUR CURRENT PROBLEMS: We appreciate your completion of this questionnaire as it helps your therapist get a better understanding of you total health status. The questionnaire is a part of your confidential medical record and your therapist will answany of your questions during your examination.		Do you have a pacemaker?	Yes	No
Do you have impaired vision? Yes No Have you experienced an increase in frequency or intensity of headaches? Yes No Current Height: ft in Weight: lbs 2. ANY OTHER MEDICAL PROBLEMS? lbs 3. Are you now or do you have any reason to believe you may be pregnant? Yes No PLEASE LIST ALL MEDICATIONS AND PURPOSES: 5. PLEASE LIST ALL SURGERIES AND APPROXIMATE DATES: 6. PLEASE LIST ALL DIAGNOSTIC TESTS FOR YOUR CURRENT PROBLEMS: 7. HAVE YOU SEEN ANYONE ELSE FOR YOUR CURRENT PROBLEMS: We appreciate your completion of this questionnaire as it helps your therapist get a better understanding of you total health status. The questionnaire is a part of your confidential medical record and your therapist will answany of your questions during your examination.		Do you have impaired hearing?	Yes	No
Have you experienced an increase in frequency or intensity of headaches? Yes No Current Height: ft in Weight: lbs 2. ANY OTHER MEDICAL PROBLEMS?			Yes	No
3. Are you now or do you have any reason to believe you may be pregnant? Yes No 4. PLEASE LIST ALL MEDICATIONS AND PURPOSES: 5. PLEASE LIST ALL SURGERIES AND APPROXIMATE DATES: 6. PLEASE LIST ALL DIAGNOSTIC TESTS FOR YOUR CURRENT PROBLEMS: 7. HAVE YOU SEEN ANYONE ELSE FOR YOUR CURRENT PROBLEMS: We appreciate your completion of this questionnaire as it helps your therapist get a better understanding of you total health status. The questionnaire is a part of your confidential medical record and your therapist will answany of your questions during your examination.		Have you experienced an increase in frequency or intensity of headaches? Current Height: ft in Weight: lbs	Yes	No
4. PLEASE LIST ALL MEDICATIONS AND PURPOSES: 5. PLEASE LIST ALL SURGERIES AND APPROXIMATE DATES: 6. PLEASE LIST ALL DIAGNOSTIC TESTS FOR YOUR CURRENT PROBLEMS: 7. HAVE YOU SEEN ANYONE ELSE FOR YOUR CURRENT PROBLEMS: We appreciate your completion of this questionnaire as it helps your therapist get a better understanding of you total health status. The questionnaire is a part of your confidential medical record and your therapist will answ any of your questions during your examination.	2.	ANY OTHER MEDICAL PROBLEMS?		
6. PLEASE LIST ALL DIAGNOSTIC TESTS FOR YOUR CURRENT PROBLEMS: The Have you seen anyone else for your current problems: We appreciate your completion of this questionnaire as it helps your therapist get a better understanding of you total health status. The questionnaire is a part of your confidential medical record and your therapist will answ any of your questions during your examination.	4.			
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Signatura	total he	ealth status. The questionnaire is a part of your confidential medical record and	tter understand your therapist	ing of you will answe
Signature Date		ure Date		

CASCO BAY PHYSICAL THERAPY

Patient Information Form	Date:				
Please print:					
Name: (Last) (First) (M)	Referrin	g Physician:			
Address:	Primary (Care Physician:			
City:	State:	Zip:			
Date of Birth: Age:	Ce	ell Phone:			
Do you want to receive text reminders for your upcon	ning physic	al therapy appointments	s? Yes	No	
Place of Employment:	Alterna	nte Phone:			
E–Mail Address:		Gender:			
In case of emergency contact:		Phone:			
Reason for Referral:					
Date of injury/onset:					
Date of Surgery:					
Work Related: Yes No Auto Accident: Y	es No	Other Accident:	Yes	No	
Patient's Primary Insurance:(Insurance Compa	any Name)	Policy No:			
Patient's Secondary Insurance: (Insurance Company Nam	e)	Policy No:			
Have you been a patient of Casco Bay Physical Thera	py before?		Yes	No	
Are you presently receiving Home Health services such as nursing, IV therapy, etc?					
Have you received speech therapy or physical therapy	this year?		Yes	No	

AUTHORIZATION TO PAY BENEFITS TO PROVIDER:

I understand fully that, in the event that my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. I hereby assign payment directly to Casco Bay Physical Therapy benefits due to me for services rendered. I understand I am financially responsible for any balance remaining after payment of benefits according to my insurance policy.

THIRD PARTY LIABILITY POLICY:

This office does not accept third party liability insurance payments, such as motor vehicle or personal injury accidents.

SUPPLIES:

I understand that I am financially responsible for all and any supplies that are given to me during the course of my treatment. Payment will be due on the day the supply is received

MEDICARE PATIENTS:

I have been notified by Casco Bay Physical Therapy that Medicare only covers 80% of all approved charges after which I am personally and fully responsible for the remaining percentage co-payment along with my annual deductible (if it has not been met). As well, I have been informed that Medicare has enforced a soft cap of \$2230 for 2023 for physical therapy and speech therapy combined, after which I would be responsible for payment of services. Most secondary insurances will not continue to pay for services denied by Medicare.

CANCELLATIONS:

Please call 24 hours in advance to cancel your scheduled appointment; otherwise there will be a \$50.00 fee to be paid at your next appointment. Thank you for your understanding and attention to cancelling any appointment you cannot attend.

Patient's initials:					
ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE:					
I, from Casco Bay Physical Therapy.	, have received the Notice of Privacy Practices				
Patient Signature:	Date:				