PATIENT INFORMATION

Patient's Full Legal Name:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Home Phone:	Cell Phone:	Social Security No.:	Birth date:	Age:	Sex: ❑M ❑ F

Full Address:

Email Address:

Occupation:	Employer:	Employer phone no.: ( )

INSURANCE INFORMATION

Please make sure we have your current and accurate insurance information on file
Any copays, deductibles, co-insurance amounts are due at time of service

Person Responsible for Bill: ❑Self ❑Spouse ❑Child ❑Other_____ **Name:**_____

Address: ❑ Same ❑_____

Insurance Subscriber: ❑Self ❑Spouse ❑Child ❑Other_____ **Name:**_____

Subscriber SSN:_____**Subscriber DOB:**_____

ACCIDENT INFORMATION

Is your diagnosis a result of an accident? ❑ Yes ❑ No ❑Motor Vehicle Accident ❑ Work Related Accident ❑Other_____

Date of Injury/Accident_____

Is an attorney involved? ❑Yes ❑No Name of Attorney/Law Firm_____

Is Workers Comp. involved? ❑ Yes ❑ No Workers Comp Company_____

IN CASE OF EMERGENCY

Name of Emergency Contact:	Relationship to patient:	Primary Phone#: ( )	Secondary Phone#: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to HALL THERAPY SERVICES. I understand that I am financially responsible for any balance. I also authorize HALL THERAPY SERVICES or insurance company to release any information required to process my claims.

HIPAA: By signing this form I acknowledge that HALL THERAPY SERVICES, LLC has made available to me their "Notice of Privacy Practices" and that I may request a copy, at any time.

CONSENT: By signing this form, I agree and give my consent for Hall Therapy Services, LLC to furnish therapy care and treatment considered necessary and proper in diagnosis and/or treating my physical condition.

Patient/Guardian Signature_____**Date**_____

Office Use Only:

Name:_____ Height:_____ Weight:_____

Referring Physician: _____ Date of next doctor visit: _____

Were you injured? YES / NO If YES, how were you injured? _____

What is the date of your injury? _____ Date of surgery: _____

Did you have any special tests performed? X-RAYS / MRI /CT SCAN / NERVE STUDY / BONE SCAN

Past Medical History: CIRCLE ANY DIAGNOSES THAT APPLY TO YOU

High Blood Pressure	Heart Disease	Heart Attack	Pacemaker/Defibrillator	Heart Surgery
Asthma	Sleep Apnea	COPD/Emphysema	Pneumonia/Bronchitis	Stroke
Seizures	Concussion	Hepatitis	HIV	Anemia
Reflux	Diabetes	Thyroid Disease	Kidney Disease	Pregnant
Rheumatoid Arthritis	Degenerative Joint	Joint Replacement	Aneurysm	Obesity

List ANY surgeries you've had: _____

Functional Limitations: CIRCLE ANY FUNCTIONS YOU ARE HAVING DIFFICULTY PERFORMING

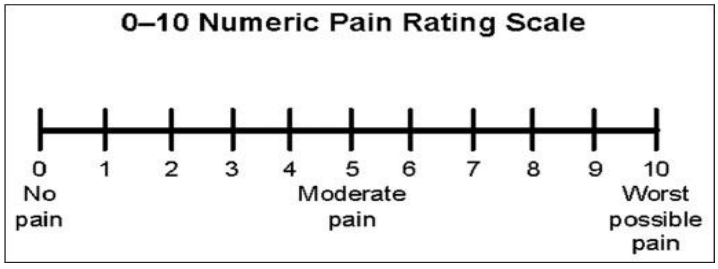
Lying Down	Sleeping thru night	Sitting	Standing	Bending
Squatting	Kneeling	Walking	Running	Lifting
Reaching	Climbing Stairs	Work Demands	Coughing	Sneezing

List ALL medications you are taking: _____

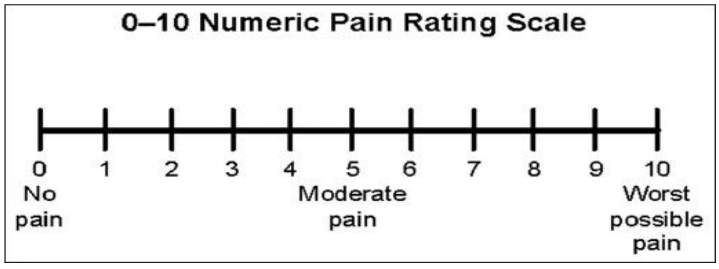
_____

Do you have any medical allergies: YES / NO If yes: _____

CURRENT Pain level

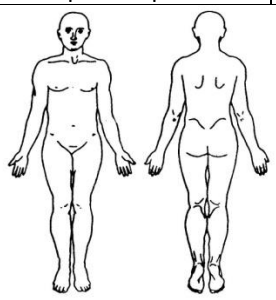


WORST Pain level



Describe your pain (CIRCLE ANY THAT APPLY TO YOU)

Constant	Comes & Goes	Sharp	Aching	Burning
Numb/Tingling	Radiates into Arm	Radiates into Leg	Stiffness	Muscle Soreness
Interrupts Sleep	Headaches			



↖↖↖ **Please indicate WHERE your symptoms are.**