Alpharetta - (678) 679-7782
11660 Alpharetta Hwy, Suite 640
Roswell, GA 30076

Cumming - (678) 679-5080
1810 Peachtree Parkway #103
Cumming, GA 30041

CONFIDENTIAL MEDICAL HISTORY

Fax (678) 965-2550 | Email admin@PTbyBodyPros.com

Name: ______________________ Date of Birth: __________ Today's Date: __________

Address: ______________________ City: __________ Sate: ________ Zip: ______________

Phone#: ______________________ Date of Injury: __________

Occupation: ______________ Employer: ________________ Work Phone: ________________

Emergency Contact: ________________________________ Phone: ________________

Is this injury Work or Auto Related? _____ Chief Complaint: ______________________

Have you had either of the following for this injury: MRI X-rays Referring MD: ______________

List all medications you are taking: ____

Are you allergic to any medications? ____

List any surgeries: ____

Do you have or have had any of the following?

	Yes	No
Asthma, Bronchitis or Emphysema		
Shortness of Breath/Chest Pain		
Coronary Heart Disease Pacemaker		
High Blood Pressure		
Heart Attach/Surgery		
Stroke/TIA		
Blood Clot/Emboli		
Epilepsy/Seizures		
Thyroid Trouble/Goiter		
Anemia		
Infectious Disease		
Diabetes		

	Yes	No
Cancer or Chemo/Radiation		
Arthritis/Swollen Joints		
Osteoporosis		
Varicose Veins		
Gout		
Sleeping Difficulties		
Emotional/Psychological Problems		
Bowel or Bladder Problems		
Severe/Frequent Headaches		
Vision/Hearing Difficulties		
Dizziness or Faintness		
Are you Pregnant		
Other:		

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Body Pros Physical Therapy regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Patient/Guardian Signature: ______________________________ **Date:** ______________

I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient/Guardian Signature: ______________________________ **Date:** ______________