BODY PROS
PHYSICAL THERAPY

**Cumming - (678) 679-5080 |** 1810 Peachtree Parkway #103, Cumming, GA 30041
**Alpharetta - (678) 679-7782 |** 11660 Alpharetta Hwy, #640, Roswell, GA 30076
**Dawsonville - (678) 528-8700 |** 671 Lumpkin Camp Ground Rd. S, #110, Dawsonville, GA 30534

# 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 | | Yes | No |
|---|---|---|---|---|---|
| Asthma, Bronchitis or Emphysema | ☐ | ☐ | Cancer or Chemo/Radiation | ☐ | ☐ |
| Shortness of Breath/Chest Pain | ☐ | ☐ | Arthritis/Swollen Joints | ☐ | ☐ |
| Coronary Heart Disease Pacemaker | ☐ | ☐ | Osteoporosis | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | Varicose Veins | ☐ | ☐ |
| Heart Attach/Surgery | ☐ | ☐ | Gout | ☐ | ☐ |
| Stroke/TIA | ☐ | ☐ | Sleeping Difficulties | ☐ | ☐ |
| Blood Clot/Emboli | ☐ | ☐ | Emotional/Psychological Problems | ☐ | ☐ |
| Epilepsy/Seizures | ☐ | ☐ | Bowel or Bladder Problems | ☐ | ☐ |
| Thyroid Trouble/Goiter | ☐ | ☐ | Severe/Frequent Headaches | ☐ | ☐ |
| Anemia | ☐ | ☐ | Vision/Hearing Difficulties | ☐ | ☐ |
| Infectious Disease | ☐ | ☐ | Dizziness or Faintness | ☐ | ☐ |
| Diabetes | ☐ | ☐ | 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:** _____