



**Tolland Physical Therapy**  
Patient Information / Medical History

Primary Care MD: \_\_\_\_\_

Referring MD: \_\_\_\_\_

Occupation: \_\_\_\_\_

Working at Present: Yes / No

Marital Status: S M W D

Children under age 18 in Household: Yes / No

Problem for which you are now coming in for Physical Therapy:

\_\_\_\_\_

Have you had Physical Therapy for this problem before?

Yes / No

When / Where: \_\_\_\_\_

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To the best of your knowledge, do you now have or have you ever had any of the following:

- |  | Yes                      | No                        |
|--|--------------------------|---------------------------|
| 1. Heart condition / attack / Cardiac Pacemaker          | <input type="checkbox"/> | <input type="checkbox"/>  |
| 2. Cancer  | <input type="checkbox"/> | <input type="checkbox"/>  |
| If yes, when: _____                                      |                          | Which part of body: _____ |
| 3. Diabetes  | <input type="checkbox"/> | <input type="checkbox"/>  |
| 4. Stroke  | <input type="checkbox"/> | <input type="checkbox"/>  |
| If yes, when: _____                                      |                          |                           |
| 5. Surgery within the past year                          | <input type="checkbox"/> | <input type="checkbox"/>  |
| If yes, when & what type of surgery: _____               |                          |                           |
| 6. Are you pregnant                                      | <input type="checkbox"/> | <input type="checkbox"/>  |
| 7. Are you allergic to aspirin, lidocaine, or cortisone? | <input type="checkbox"/> | <input type="checkbox"/>  |
| Please list any other allergies: _____                   |                          |                           |
| 8. Other medical conditions: _____                       |                          |                           |
| 9. Medications: _____                                    |                          |                           |

I certify that the above information is true to the best of my knowledge.

Patient / Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Tolland Physical Therapy

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please briefly tell us why you have come to physical therapy:

If it is an injury, please tell us:

When it occurred:

Where it occurred:

How it occurred:

What areas are affected:

How did you first hear of Tolland Physical Therapy?

Have you seen any of our ads and if so, in which publications?

## Consent and Acknowledgment Form

I consent to the use or disclosure of my protected health information by TOLLAND PHYSICAL THERAPY ("TPT") to any person or organization for the purposes of carrying out treatment, obtaining payment, or conducting certain healthcare operations. I understand that information regarding how TPT will use and disclose my information can be found in TPT's Notice of Privacy Practices. I understand that this consent is effective for as long as TPT maintains my protected health information.

Do you wish to designate a person or persons with whom TPT may discuss your care?

If so, please list: \_\_\_\_\_

\_\_\_\_\_

By signing below, I understand and acknowledge the following:

- I have read and understand this consent; and
- I have a right to a copy of TPT's Notice of Privacy Practices currently in effect.

\_\_\_\_\_  
Print Name of Individual or Personal Representative

\_\_\_\_\_  
Signature of Individual or Personal Representative

\_\_\_\_\_  
Date

If signed by the individual's representative, describe the legal authority of the representative to act on the behalf of the individual: \_\_\_\_\_

Unable to obtain written consent and acknowledgment because:

- Individual refused
- Emergency treatment situation
- Individual not able to sign due to incompetence or other medical reason
- Other: \_\_\_\_\_