Evolution Medical Associates

604 Druid Rd. E. Clearwater, FL 33756 P: 727-216-3492 F: 727-216-3495

We're delighted you're here! Who can we thank?

Dr referral: ___________________________ **Friend/Family name:** __________________________________

Our Website: ____ **Facebook:** ___ **Yelp:** ___ **Twitter:** ___ **Pinterest:** ___ **GOOGLE:** ____ **Other:** ______

Patient #______________ **(Office Use Only)**

Date of Appointment: ______________ **Time:** ___________ **Appt w/**_____________________

Mr. Mrs. Miss Ms. Dr. **Preferred/Nickname:** ____________________ Birth Date: ______________

(**Please PRINT**) Please Circle: Female / Male Marital Status: S M W D P

Name: ____

Address: _____________________________ City, State, **Zip**: ___________________________________

Occupation: _________________________ Employer: ____

SS#: _________________________________ E-Mail: ____

*SS# optional for identification; **ONLY required for VA*** *Email address required for email appt reminder*

____

Home Phone Number: (______)_______________ Cell Phone: (______)____________________

Cell Phone number required for text appt reminder

Work Phone Number: (______)_______________ ****Best Way to Reach You**: Home Cell Work

Emergency Contact: ____

(Name, relationship & phone number with area code)

Please Circle Your Appointment Reminder Preference: Text / Email / None

Primary Physician's Name: ____________________________ PCP's Phone: _____________________

Referring Doctor's Name: _____________________________ Dr.'s Phone #: ____________________

Doctor's Address: _____________________________________ Dr.'s FAX #: ______________________

MY PAYMENT METHOD: (Please circle ONE)

Physical Therapy – **CASH VA TRADITIONAL MEDICARE* ****

Cash Payment will be made when treatment is rendered. Detailed receipts are available.
Cash; Check; FSA/HSA cards *or* Credit/Debit cards (Visa; Master Card; American Express or Discover)

***Medicare Home Healthcare Verification**: I hereby verify that I have NO open home healthcare order. I agree that failure to disclose an Open Home Healthcare Order will result in Medicare denying my claim; I assume all financial responsibility and will pay for the treatment(s) I receive(d). __________ (Initial)**

**** I confirm I understand Evolution Medical Associates is "In Network" with Traditional Medicare ONLY. _____ (Initial)**

Privacy Statement: Your information will be shared only with your doctors and other healthcare practitioners directly involved in your care. If using insurance, information will be sent to insurers as requested. Full HIPAA forms available upon request. Rev. 8.1.19

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(Please PRINT)

PATIENT HISTORY FORM

Today's Date: _______________

Name: ____ Birth Date: _____________ ___________

Do You Smoke? Y N How Much? How Often? _____________________________________ ___________

Drink Alcohol? Y N How Much? How Often? ______________________________________ ___________

HEAD
___ Brain Injury
___ Seizures
___ Aneurysm
___ Encephalitis

EYES
___ Glaucoma
___ Cataracts

EARS
___ Miniere's
(Type: ______________)
___ Hearing Loss
___ Tinnitus

THROAT
___ Sleep Apnea
___ Snoring
___ Thyroid Disease

LUNGS
___ Emphysema
___ Pleurisy
___ Pneumonia
___ Asthma

HEART
___ Atrial Fibrillation
___ Blood Clots
___ High Blood Pressure
___ Irregular Heart Rate
___ Pacemaker
___ _________________

JOINTS
___ Osteoarthritis
___ Rheumatoid Arthritis
___ Gout
___ Osteoporosis
___ Osteogenesis Imperfecta
___ Broken Bones:
(__________________)

NEUROLOGICAL
___ Multiple Sclerosis
___ Polio
___ Parkinson's
___ Stroke
___ Meningitis
___ Migraines

GYN
___ # of Pregnancies
___ Cramps
___ Endometriosis
___ Fibroids

ENDOCRINE
___ Diabetes Mellitus Type 1
___ Diabetes Mellitus Type 2
___ Hypoglycemia

DISEASES
___ HIV / AIDS
___ Hepatitis
___ TB

MISCELLANEOUS
___ Cancer
(Type: ______________)
___ Anxiety
___ Depression
___ Panic Attacks
___ CFS
___ Fibromyalgia
___ GERD (Acid Reflux)

OTHER: ____

SURGERIES: ____

Allergies: ____

Current Prescription Medications: ____

____

Current Over the Counter Medications: ____

Vitamins / Supplements / Herbs: ____

____

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People we may talk to about your status (circle): Spouse/Partner Children Parents Siblings Physicians (other than referring) Other Healthcare practitioners Other (specify):______________________________

Home Situation: Do you live in a (circle): House Apartment Condo Mobile Home

Do you live alone? Yes No If no, who do you live with?__________________________________

Number of steps to enter home: __________ Number of steps inside home: ________

PHYSICAL THERAPY PATIENT HISTORY

Today's Date: ____________________

Name: ____ Birth Date: ____________________________

Height: ____ **Weight**: ____

Reason for today's visit: ____

Have you seen a doctor for this problem? ____

What Tests/Surgeries have you had done for this problem? ____

Other current Therapies: ____

When did this problem begin? ____

What caused this problem? ____

Rate Your Pain and/or Swelling on a Scale of 0 – 10 (0 = NO Pain; 10 = Go to the Emergency Room) :

At it's **Best** __________ At it's **Worst** __________ **Today** __________

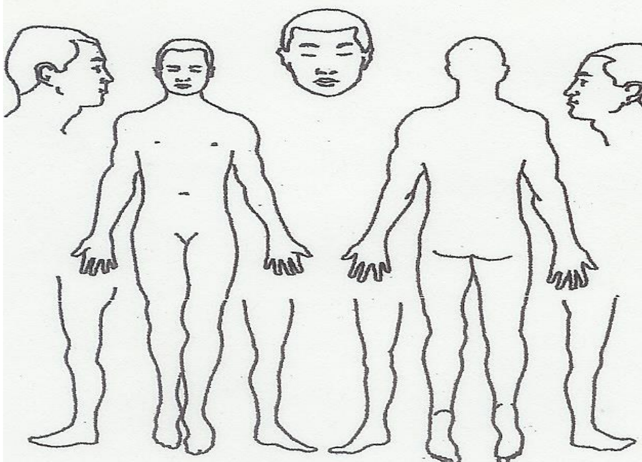
Is Your Pain and/or Swelling Constant? ______________________ Or, Does it Come and Go? _________________________

Is it Worse in the Morning? _________________ Midday? _________________ Or, in the Evening? _________________

How Often do You have this Pain and/or Swelling? ____

Activities or Movements that are Painful to Perform: Reaching_______ Lifting________

Sitting _______ Standing _______ Walking _______ Bending _______ Lying Down _______



Please mark on this drawing

Areas where you have

Pain and/or Swelling.

Limitations you Currently have due to your Pain and/or Swelling. (Sleep, Self-Care, Socializing, etc.): _____________________________

____

____

Previous activity level, including exercise, recreation, job, etc.: ____

____

____

Do you have any difficulty getting around your home? If so, Explain: ____

____

What is your Goal for this therapy?: ____