Chautauqua Physical & Occupational Therapy

Medical History Form

Patient Name: _____ DOB: _____

MEDICAL HISTORY (Please describe any "yes" answers in the box below)

Abnormal Blood Pressure	O Yes O No	Diabetes	O Yes O No	Metal Implants	O Yes O No
Allergies	O Yes O No	Dizzy Spells	O Yes O No	MRSA	O Yes O No
Anemia	O Yes O No	Emboli/Blood Clots	O Yes O No	Multiple Sclerosis	O Yes O No
Anxiety	O Yes O No	Emphysema/Bronchitis	O Yes O No	Muscular Disease	O Yes O No
Arthritis	O Yes O No	Fibromyalgia	O Yes O No	Osteoporosis	O Yes O No
Asthmas	O Yes O No	Fractures	O Yes O No	Parkinson's Disease	O Yes O No
Autoimmune Disorder	O Yes O No	Gallbladder Problems	O Yes O No	Rheumatoid Arthritis	O Yes O No
Cancer	O Yes O No	Headaches	O Yes O No	Seizures	O Yes O No
Cardiac Conditions	O Yes O No	Hearing Impaired	O Yes O No	Smoking	O Yes O No
Cardiac Pacemaker	O Yes O No	Hepatitis	O Yes O No	Speech Problems	O Yes O No
Chemical Dependency	O Yes O No	High Cholesterol	O Yes O No	Strokes/TIA	O Yes O No
Chest Pain/Short of Breath	O Yes O No	HIV/AIDS	O Yes O No	Thyroid Disease	O Yes O No
Circulation Problems	O Yes O No	Infectious Disease	O Yes O No	Tuberculosis	O Yes O No
Currently Pregnant/Trying	O Yes O No	Incontinence-Bladder/Bowel	O Yes O No	Vision Problems	O Yes O No
Depression	O Yes O No	Kidney Problems	O Yes O No		

FALLS HISTORY Current injury is a result of a fall in the past year: O Yes O No Date of fall: _____

Two or more falls in the last year?: O Yes O No Dates of falls: _____

SURGICAL HISTORY (please list additional surgeries on back of sheet)

Body Region: _____ Surgery Type: _____ Date(mm/dd/yyyy): _____

Body Region: _____ Surgery Type: _____ Date (mm/dd/yyyy): _____

Body Region: _____ Surgery Type: _____ Date (mm/dd/yyyy): _____

CURRENT MEDICATIONS (please list additional medications on back of sheet)

Drug: _____ Dosage: _____ Frequency: _____ Reason for Taking: _____

How do you take this medication: _____

Drug: _____ Dosage: _____ Frequency: _____ Reason for Taking: _____

How do you take this medication: _____

This consent provides us with your permission to perform reasonable and necessary evaluations and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite offices under common ownership of The Chautauqua Center/Chautauqua Physical & Occupational Therapy including visits that are conducted through telehealth (audio and video) means. The consent will remain fully effective until it is revoked in writing. You have the right to discontinue at any time services being provided.

You have the right to discuss the treatment plan with your provider about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions. I voluntarily request a physical therapist, physical therapy assistant, occupational therapist, certified occupational therapist assistant or speech-language pathologist as deemed necessary, to perform reasonable and necessary evaluations and treatment for the condition which has brought me to seek care at this practice.

I certify that the insurance information which I have provided is complete and correct. I accept the responsibility of advising and providing TCC/CPT, prior to service, of no fault or workers' compensation information for treatment of eligible inquires or illnesses. I authorize TCC/CPT to release medical information necessary to process insurance claims and release information back to my physician. By my signature below, I hereby consent to treatment, assignment of financial benefits directly to The Chautauqua Center and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its consents.

Patient/Parent/Guardian Signature: _____ Date: _____