THE SMITH CLINIC
For Physical Therapy
Orthopaedics · Sports Medicine · Golf Conditioning

8110 Cordova Road, Ste 107, Cordova, TN 38016
Phone: (901) 756-1650 Fax: (901) 756-1396
www.thesmithclinic.com

Confidential Patient Information

Patient Name: _____ Date Of Birth: ___/___/___ Referring MD: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___)_____Cell/Work Phone: (___)_____ SSN: _____ Sex: F or M

Occupation: _____ Is this injury: Work Related_____ Auto Accident _____Date Of Injury: _____

Primary Insurance:_____ Subscriber ID:_____ Group#_____

Secondary Insurance:_____ Subscriber ID:_____ Group#_____

Please answer the following questions regarding your therapy:

Have you attended physical therapy, occupational therapy, or been seen by a chiropractor this year? Yes___No____

If so, were your treatments related to the same injury you are being treated for at The Smith Clinic? Yes___No____

How many treatments have you had? _____

Please provide the name of a friend or relative that we may contact in the event of an emergency:

Name: _____ Relation:_____Phone:(___)_____

Please let us know who we can thank for sending you to our clinic:

Name: _____

We occasionally send out information to our patients through email. Please provide us your email address so we can keep you informed. Thank you.

_____

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 I am responsible to inform the office of any changes that occur. I authorize release of payment directly to The Smith Clinic 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/Parent or Guardian Signature: _____Date:_____

I acknowledge 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/Parent or Guardian Signature: _____Date:_____

Medical History **Name: _____**

Weight:_____ Height: _____ Chief Complaint:_____

Please circle your pain level at ***BEST:*** 1 2 3 4 5 6 7 8 9 10
Please circle your pain level at ***CURRENTLY:*** 1 2 3 4 5 6 7 8 9 10
Please circle your pain level at ***WORST:*** 1 2 3 4 5 6 7 8 9 10

Current Symptoms: Pain____ Numbness____ Stiffness____ Weakness____ Condition: New____ Chronic____

Current Medicines (if you have a list we can make a copy):_____

Medical Allergies: _____ Other Allergies: _____

Have you experienced any falls within the last 6 months? If yes, how many? _____

Have you had any Diagnostic or Rehabilitative Services for this Injury? ☐ MRI ☐ X-rays Other_____

Do you have any of the following?

	YES	NO
Asthma, Bronchitis or Emphysema	____	__
Shortness of Breath/ Chest Pain	____	___
Coronary Heart Disease	____	___
Do you have a Pacemaker	____	___
Heart Attack/ Surgery	____	___
Stroke/ TIA	____	____
Blood Clot/ Emboli	____	____
Epilepsy/ Seizures	____	____
Thyroid Trouble/ Goiter	____	____
Anemia	____	____
Infectious Disease	____	____
Diabetes	____	____
Cancer or Chemo/ Radiation	____	____
Arthritis/ Swollen Joints	____	____
Osteoporosis	____	____
Varicose Veins	____	____
Gout	____	____
Sleeping Difficulties	____	____
Bowel or Bladder Changes	____	_____
Dizziness or Faintness	____	____
Severe/ Frequent Headaches	____	____
Vision/ Hearing Difficulties	____	____
High Blood Pressure	____	____

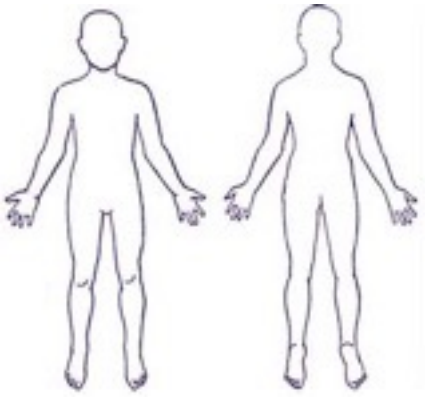
Pain and/or difficulty when performing the following activities?

	Mild	Moderate	Severe	Unable
Bending	____	____	____	____
Care for Infirm Family	____	____	____	____
Carrying Groceries	____	____	____	____
Change Pos(Sit to Stand)	____	____	____	____
Driving	____	____	____	____
Extended Computer Use	____	____	____	____
Feeding (Self)	____	____	____	____
Household chores	____	____	____	____
Kneeling	____	____	____	____
Lifting	____	____	____	____
Pet Care	____	____	____	____
Self Care (Bathing)	____	____	____	____
Self Care (Dressing)	____	____	____	____
Sleep	____	____	____	____
Sitting (Prolonged)	____	____	____	____
Standing (Prolonged)	____	____	____	____
Walking	____	____	____	____
Yard Work	____	____	____	____
Climbing Stairs	____	____	____	____

Sports _____
Recreational Activities_____
Exercise Daily_____ Weekly_____

Are you pregnant? Yes ____ No ____ Other Medical Conditions _____
Are you aware of your Diagnosis? Yes___ No ___

Please mark an (X) on the body image where your pain exists and then indicate if it moves to another area on your body



Financial Policy

Please be aware that we will be collecting on your physical therapy benefits, which are selected by your insurance company. These benefits were not selected by our clinic, and would be the same regardless of which clinic you choose to attend for physical therapy. We will collect your deductible, co payment or charge for self-pay for visits at the time of your visit. Cash, check, and all credit cards are accepted.

Please note: By Federal Law and Managed Care Contract Law, this office is required to collect co payment and deductibles for each customer. Penalty for not following this requirement could result in the termination and cancellation of medical coverage for this patient.
We do appreciate you choosing us for your physical therapy treatment. We are almost always willing and able to work with you on a payment plan. If you have any questions you may talk with anyone in the front office after we have gone over your benefits.

I understand that The Smith Clinic will charge a $20 fee for appointments missed without prior notification. Fee will be applied if a six hour notification is not given.

Patient/Parent of Guardian Signature: _____ **Date:** _____

Media Release

We occasionally take pictures of our staff and patients to be used on various online or printed materials. I hereby hold harmless, and release The Smith Clinic For Physical Therapy from all liability. I grant The Smith Clinic For Physical Therapy the right to take pictures of me to be used in and/or for promotional materials, including: social networking sites, website, newsletters, brochures and/or advertisements, without payment or any other consideration.

Print Name: _____

Signature: _____ **Date:** _____

If under 18, a Parent or Legal Guardian must sign:

Name of parent or legal guardian: _____

Signature of parent or legal guardian: _____

Date: _____