



Committed to EXCELLENCE in
Physical Therapy & Sports Rehab

Ortho Advantage Medical History

Name _____ Date of Birth _____
Street Address _____ City _____
State ____ Zip _____ Home Phone _____
Cell Phone _____ Email Address _____
Occupation _____ Currently working? YES /NO
Job Demands _____

Smoker _____	Pacemaker _____	Cancer _____
Diabetes _____	Heart Attack _____	Lung Disease _____
Short of Breath _____	Heart Surgery _____	High Blood Pressure _____
Stroke _____	Metal Implants _____	Recent Wt Loss/Gain _____
Defibrillator _____	Bowel/Bladder Dysfunction _____	

Other _____

CURRENT MEDICATIONS? _____

Currently seeking therapy for? _____

Date of Injury / Surgery _____ / _____

Previous treatment for this condition: YES / NO When / # Treatments? _____

Any Diagnostic Testing?(circle) X-Ray CT Scan MRI EMG Bone Scan

When? _____ Where? _____

Do you use any braces or supports? YES / NO What kind? _____

Do you need assistance with activities at home? YES / NO

With what asks? _____

Hand Dominance? LEFT / RIGHT

Reviewed by Therapist _____ Date: _____

AUTHORIZATION FOR TREATMENT

I the undersigned consent to and authorize treatment which may be considered advisable by the attending physician or their designates. I acknowledge no guarantees have been made as to the results of treatment.

FINANCIAL AGREEMENT

All charges are my responsibility. I assign and authorize payment to be made directly to Ortho Advantage, LLC all insurance benefits and agree to pay any balance due. I hereby authorize any holder of medical information about me, to release to the Health Care Financing Administration and its agent, any information needed in determining those benefits payable for related services. I hereby authorize Medicare to furnish to Ortho Advantage, LLC any information regarding my Medicare claims under title XVII of the Social Security.

Signature _____ Date: _____