Back to You
Physical Therapy & Sports Medicine

19 North Main Street, Suite 1A
Sherborn, MA , 01770
p. 508. 545. 2352 f. 508. 545. 2354

PLEASE PRINT CLEARLY AND COMPLETE ALL ITEMS FOR PROPER PROCESSING OF YOUR CLAIM

SEC 1

NAME _____ _____ _____ SEX ☐ M ☐ F
FIRST MI LAST

ADDRESS _____
STREET APT.# CITY STATE ZIP

PHONE _____ MOBILE _____ D.O.B. _____

EMAIL _____

EMERGENCY CONTACT _____ PHONE _____

If you do not wish to receive informational emails, you may opt out by checking the following box. ☐

SEC 2 ***HOW DID YOU HEAR ABOUT US?***

☐ MD REFERRED _____ ☐ MD REFERRAL LIST ☐ INSURANCE CO. WEBSITE
PHYSICAN'S NAME

☐ SIGN/DRIVING BY ☐ FORMER PATIENT _____
PATIENT NAME

☐ FACE BOOK/ NEXT DOOR ☐ INTERNET SEARCH ENGINE (GOOGLE, YELP)

SEC 3 ***HEALTH COVERAGE***

PRIMARY INSURANCE _____ PCP _____
NAME (PRIMARY CARE PHYSICIAN)

SUBSCRIBER _____ PCP TOWN _____

RELATION TO THE INSURED ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SECONDARY INSURANCE _____
NAME

SEC 4 ***TYPE OF INJURY***

IS THIS INJURY RELATED TO AN ACCIDENT AT WORK? OR AN AUTO ACCIDENT? ☐ YES ☐ NO

SEC 5 ***CONSENT FOR TREATMENT***

I THE UNDERSIGNED, A PATIENT OF BACK TO YOU PHYSICAL THERAPY & SPORTS MEDICINE INC., DO HEREBY CONSENT TO TREATMENT AS PRESCRIBED BY MY PROVIDER, A LICENSED PHYSICAL THERAPIST IN THE STATE OF MASSACHUSETTS.

I HAVE READ AND UNDERSTAND THE CONSENT FOR TREATMENT _____ PATIENT INITIALS

SEC 6 ***HIPPA NOTICE OF PRIVACY PRACTICES***

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF AND PROVIDE INDIVIDUALS WITH A NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION.
YOUR SIGNATURE BELOW IS ONLY TO ACKNOWLEDGE THAT YOU HAVE BEEN GIVEN A NOTICE OF OUR PRIVACY PRACTICES.

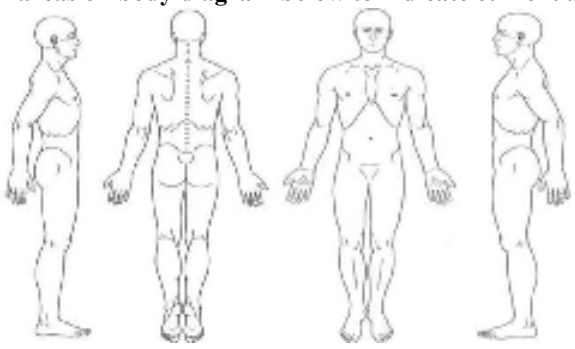
_____ _____
PATIENT SIGNATURE DATE

Back to You
Physical Therapy & Sports Medicine

PATIENT HEALTH QUESTIONNAIRE

Name:_____ Date of Birth:_____Age:_____Right / Left Hand dominant

Please shade in areas on body diagram below to indicate current areas of pain:



What is the reason for your visit? _____

Have you had Physical Therapy in last 12 months? **YES** or **NO** How many visits? _____

Have you had Home Care? **YES** or **NO** If YES, what was Discharge date ___/___/____

Are your symptoms: □ Improving □ Getting Worse (Evolving and/or Changing) □ Staying the Same □ My pain is different depending on the activities □ My pain (fluctuates in intensity and duration, is unpredictable)

Height _____ Weight _____

Have you had x-rays, MRIs, or other special tests performed for your current problem? **Yes / No** Please give dates and results.

_____

_____

Are you currently pregnant? **Y / N** Do you have allergies/**latex sensitivity**? _____

Medical History (check conditions that may apply)

___ Arthritis
___ Broken bones/fractures
___ Osteoporosis
___ Circulation/vascular problems
___ Heart Problems
___ High blood pressure
___ Pacemaker/Defibrillator
___ Stroke
___ Diabetes
___ Headaches
___ Lung problems
___ Other:_____

___ Low blood sugar/hypoglycemia
___ Head injury
___ Multiple Sclerosis
___ Bowel or Bladder problems
___ Parkinson's Disease
___ Seizure/epilepsy
___ Developmental/growth problems
___ Thyroid problems
___ Dizziness
___ Cancer (type) _____

___ Tuberculosis
___ Hepatitis, HIV+, infectious disease
___ Shortness of breath/chest pains
___ Unexplained weight loss/gain
___ Ulcers/stomach problems
___ Vision problems
___ hearing problems
___ Balance problems, history of falls
___ Nausea/vomiting
___ Depression

List all past surgeries (month/year)_____

_____

List all medications you are currently taking_____

_____

_____

_____

Patient Signature:_____**Date:**_____

19 North Main Street, Suite 1A, Sherborn, MA, 01770
p. 508. 545. 2352 f. 508. 545. 2354
www,backtoyoupt.com