808 Bayou Ln
Thibodaux, LA 70301 US
(985) 447-3164

1321 Grand Caillou Rd
Houma, LA 70363 US
(985) 876-1155

125 Bayou Gardens Blvd
Houma, LA 70364 US
(985) 223-4760

PATIENT INFORMATION

First Name: | Last Name: | Middle Initial: | Date: / /

Address: | City: | State: | Zip:

Email Address:

Birth Date: / / | Age: | ☐ Male ☐ Female | S.S. #: - -

Home Phone: ( ) - | Alternative Phone (Cell, Pager): ( ) - | Spouse:

Chose Clinic Because/ Referred to Clinic by Dr.: ☐ Insurance Plan ☐ Word of Mouth:

☐ I am a Former Patient ☐ Close to Work/Home ☐ Web Search/Website ☐ Drive-by ☐ Advertisement

WORK INFORMATION

Employer: | Work Phone: ( ) - | Ext.

Occupation: | Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed

CARE PROVIDER INFORMATION

Referring Dr: | Phone: ( ) -

Regular Dr./PCP | Phone: ( ) -

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance Name:

Subscriber's Name (If different): | Birth Date: / /

ID. #: | Group/Policy #: | Policy Holder's SSN:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Name of Secondary Insurance:

Subscriber's Name: | Birth Date: / /

ID. #: | Group/Policy #

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

AUTO OR WORK INJURY CLAIM

(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)

Insurance Name: ☐ Auto: ☐ Labor & Industries:

Adjuster/Claim Manager: | Phone: | Ext.:

Address: | City | State: | Zip:

Claim #: | Accident Date: / / | Cause:

IN CASE OF EMERGENCY

Name of Local Relative or Friend:

Relationship to Patient: | Home Phone: ( ) - | Work Phone: ( ) -

Please provide the name of the person(s) to whom Weiss Physical Therapy Associates, P.C. may disclose health information

Name: | Relationship to Patient: | Phone: ( ) -

May we send an email or leave messages regarding appointments or treatment on your answering machine? ☐ Yes ☐ No

I have read and agree to the above, including the authorization to disclose my health information to the named recipient(s). Additionally, I authorize my insurance benefits be paid directly to Daigle Himel Daigle Physical Therapy & Hand Center and authorize said practice to release any information required to process my claim. I understand that I am financially responsible for any remaining balance.

PATIENT /GUARDIAN SIGNATURE DATE

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PAST MEDICAL HISTORY FORM

Patient Name ____________________

BLOOD PRESSURE	YES	NO
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Arrhythmia(s)	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
Do you have a pacemaker?	☐	☐

MUSCLE CONDITION	YES	NO
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐
Muscular Dystrophy	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
COPD	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐
Rheumatoid Arthritis	☐	☐
Osteoarthritis	☐	☐

OTHER CONDITIONS	YES	NO
Carpal Tunnel R/L	☐	☐
Parkinson's Disease	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Polio	☐	☐
High Cholesterol	☐	☐
Osteoporosis	☐	☐
Anxiety	☐	☐
Cancer	☐	☐
Depression	☐	☐
Stroke	☐	☐
Thyroid Condition	☐	☐
Other:		

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day ____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week ____
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week ____
☐ 5+ x Week	☐ Heavy Labor			
	☐ Other			

What types of exercise do you perform? ____________________

What things cause stress in your life?

Are you taking any seizure medication? ☐ Yes ☐ No If yes list name: ____________________

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?
☐ Yes ☐ No If yes list name: ____________________

List all medications you are currently taking: ____________________

List all surgeries (including dates): ____________________

Are you pregnant? ☐ Yes ☐ No What week? ________

Have you had any injuries related to work? ☐ Yes ☐ No If yes list body part and date.: ____________________

Have you had any auto accidents? ☐ Yes ☐ No If yes list body part and date.: ____________________

Have you had Physical Therapy or Massage Therapy before? ☐ Yes ☐ No Where:

____________________ Signature of Patient, Parent, Guardian, Personal Representative

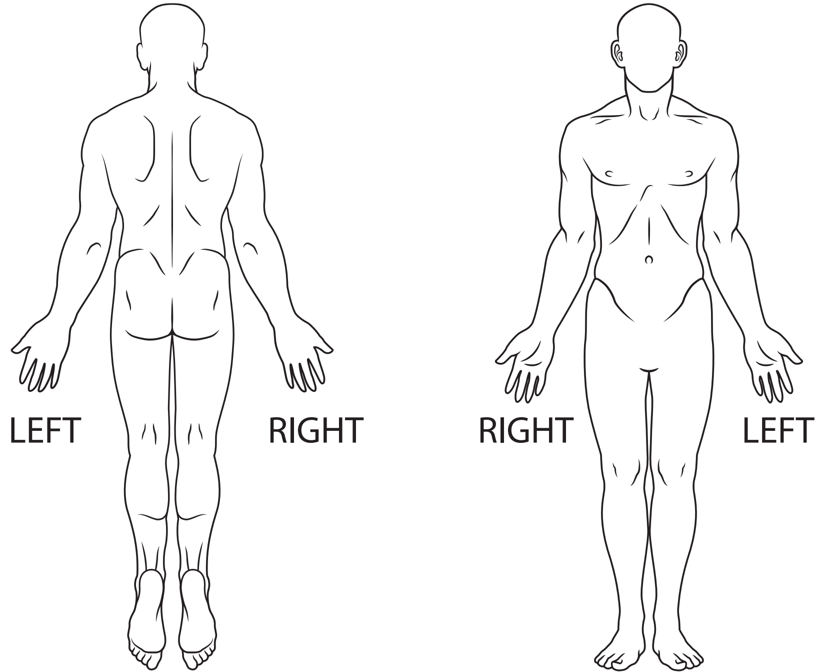
____________________ Date

Pain and Symptom Status Report

Name____Date______________________________________

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing.

Ache	Burning	Numbness
MMM M	— — — — —	0 0 0 0 0 0 0
Pins and Needles	**Stabbing**	**Other**
□ □ □ □ □ □ □ □ □ □	/ / / / / / / / /	x x x x x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is: ____

Date First Symptom of Your Problem Occurred on: ________________________

2nd Complaint:____

3rd Complaint: ____

Please circle on the scale below to indicate your CURRENT level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**
Please circle on the scale below to indicate your LOWEST level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**
Please circle on the scale below to indicate your HIGEST level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**

Additional Comments: ____

____

What goals do you wish to achieve in physical therapy? ____

____

____

____

____

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CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information (PHI) will be used by this practice, known as Daigle Himel Daigle Physical Therapy & Hand Centeror disclosed to others for the purpose of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

We are providing you with a copy of our Notice of Privacy Practices. We request that you review the notice prior to signing this consent. You may request a restriction on the use or disclosure of your protected health information. If you wish to restrict your disclosure, you should make that request in writing.

This practice, however, may or may not agree to restrict the disclosure of your protected health information.

If we agree to your request, the restrictions will be binding. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

You may revoke the consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received will not be affected.

This practice reserves the right to modify the privacy practices outlined in the notice.

SIGNATURE

I have reviewed this consent form and have reviewed the Consent to Use and Disclose Protectd Health Information. I give my permission to this practice to use and disclose my health information in accordance with it.

____

Name of Patient (Print Clearly)

____

Signature of Patient Date

____

Signature of Patient Representative

____

Relationship of Patient Representative to Patient