W O O D L Y N
P H Y S I C A L   T H E R A P Y

412 MacDade Boulevard
Milmont Park, PA 19033

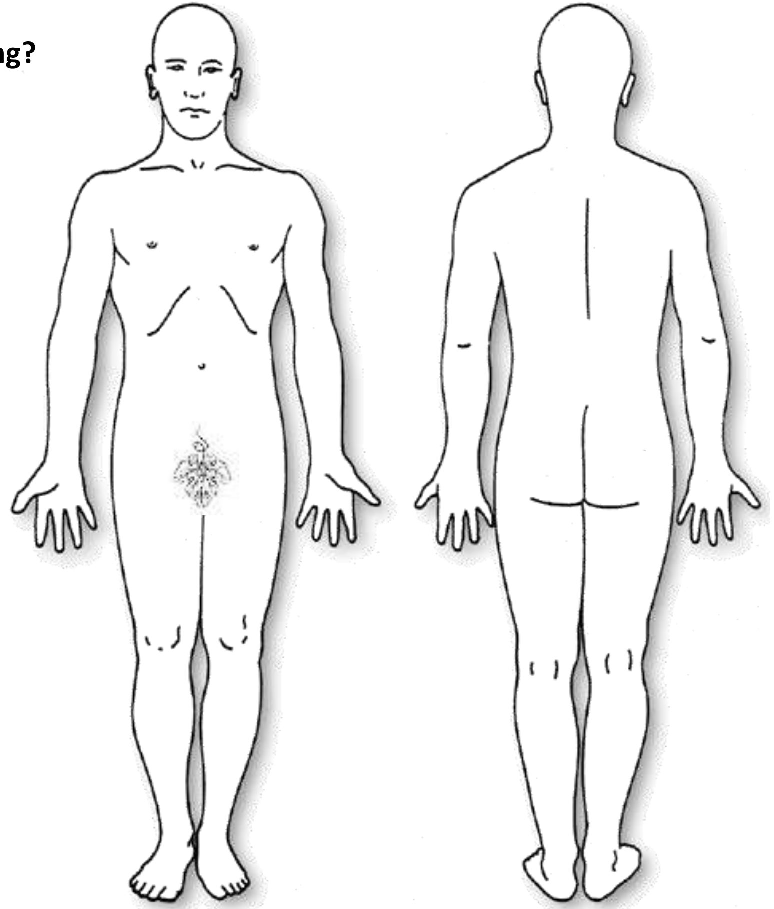
TEL:(610)583-1133 • FAX: (610)583-0855

**PLEASE ANSWER QUESTIONS 1-9. **

Patient Name: ____ **Date:** ____/___/201__

1. **Date of injury/onset**: ______/______/20___
2. **Have you ever had these symptoms before?** ❑yes ❑no
3. **Check which apply to your symptoms?**
   ❑ work related injury ❑ recurrence of previous injury ❑ motor vehicle accident ❑ injury related to lifting
   ❑ athletic/recreational injury ❑ cause unknown ❑ other: _____________________
4. **Have you had a related surgery?** ❑ yes ❑ no
5. **Do you have or have you had any of the following?**

Diabetes	❑ yes ❑ no
Chest Pain/Angina	❑ yes ❑ no
High Blood Pressure	❑ yes ❑ no
Headaches	❑ yes ❑ no
Kidney Problems	❑ yes ❑ no
Are you pregnant?	❑ yes ❑ no
Cancer	❑ yes ❑ no
Bowel/Bladder Abnormalities	❑ yes ❑ no
Asthma/Breathing Difficulties	❑ yes ❑ no
Liver/Gall bladder Problems	❑ yes ❑ no
Smoking	❑ yes ❑ no
Hernia	❑ yes ❑ no
Seizures	❑ yes ❑ no
Metal Implants	❑ yes ❑ no
Dizziness/Fainting	❑ yes ❑ no
Recent Fractures	❑ yes ❑ no
Surgeries	❑ yes ❑ no
Skin Abnormalities	❑ yes ❑ no
Nausea/Vomiting	❑ yes ❑ no
Osteoporosis	❑ yes ❑ no
Rheumatoid Arthritis	❑ yes ❑ no
Pacemaker	❑ yes ❑ no
Heart Disease	❑ yes ❑ no



If yes to any of the above, please briefly explain and give approximate Date: ____/___/20____

____

____

____

6. **Are you presently taking medication?** ❑ yes ❑ no. If yes, please list what medication & for what condition:

____

____

____

7. **Rate the intensity of your pain on a scale of 0 to 10**, zero being no pain and ten being the worse pain possible: 0 ________5________10
8. On the pictures above, please indicate where your pain is located.

WOODLYN
PHYSICAL THERAPY

412 MACDADE BOULEVARD
MILMONT PARK, PA 19033

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PATIENT INFORMATION

PATIENT NAME: ____

SS#____-____-______ DOB____/___/____ PHONE: (_____)-_____-_______

HOME ADDR____ City: ___________________ State: ____ Zip: _______

CELL PHONE (_____)-_____-_______ EMAIL ADDRESS__________________________@________________.____

REFERRING PHYSICIAN________________________________ FAMILY PHYSICAN: _____________________________________

PATIENT'S EMPLOYER

EMPLOYER NAME: ____

POSITION: ____ PHONE: (_____)-_____-_______

BUS ADDR: ____ City: ___________________ State: ____ Zip: _______

SPOUSE 'S NAME : ____

SPOUSE 'S EMPLOYER ____

POSITION: ____ PHONE: (_____)-_____-_______

BUS ADDR: ____ City: ___________________ State: ____ Zip: _______

EMERGENCY CONTACT: PHONE: (_____)-_____-_______ RELATIONSHIP __________________________________

IF A MINOR OR STUDENT, PLEASE COMPLETE THE FOLLOWING:

FATHER'S NAME: _____________________________________ SS#____-____-______ DOB____/___/____

MOTHER'S NAME: ____________________________________ SS#____-____-______ DOB____/___/____

COMPLETE ONLY IF DIFFERENT THAN ABOVE INFORMATION:

ADDRESS: ____ City: ___________________ State: ____ Zip: _______

FATHER'S PHONE: (_____)-_____-_______ MOTHER'S PHONE: (_____)-_____-_______

INSURANCE INFORMATION (PLEASE CHECK WHICH APPLIES)

DATE OF INJURY/ ILLNESS: ____/___/20___ ❑ WORK RELATED INJURY ❑ AUTO ACCIDENT ❑ OTHER/HEALTH

ATTORNEY INFORMATION (Please be advised attorneys shall not be used as Insurance information)

ATTORNEY NAME: ____ PHONE: (_____)-_____-_______

ADDR____ City: ___________________ State: ____ Zip: _________

AUTHORIZATION & RELEASE

I AUTHORIZE RELEASE OF ANY INFORMATION BOTH IN WRITING & VERBALLY, CONCERNING MY (OR MY CHILD'S) HEALTH CARE, ADVICE & TREATMENT PROVIDED FOR THE PURPOSE OF EVALUATING AND ADMINISTERING CLAIMS FOR INSURANCE BENEFITS TO EMPLOYERS AND / OR OTHER HEALTH CARE PROVIDERS. I ALSO HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THIS.OFFICE. THE SIGNER [BELOW] ACKNOWLDGES THAT I AM FIANCIALLY RESPONSIBLE FOR ANY NON-COVERED SERVICES, INCLUDING: COPAYMENTS WHICH ARE DUE ON A WEEKLY BASIS, UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE [IN WRITING].

X____ DATE____/___/201__

SIGNATURE OF PATIENT (OR PARENT IF MINOR)

How did you hear about Woodlyn Physical Therapy, Inc.?

❑ Friend ❑ Attorney ❑ Doctor ❑ Family ❑ Insurance Company