



# MCKEAN Physical Therapy

9065 Main Street, McKean, PA, 16426  
P: 814-476-3070 | F: 814-476-3076

DATE: \_\_\_\_\_

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Spouse or Parent Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Spouse or Parent Employer: \_\_\_\_\_ Spouse or Parent Date of Birth: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Date of Return: \_\_\_\_\_

Nature of Problem: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Work Related Y/N: \_\_\_\_\_ Auto Accident Y/N: \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

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Name of Insurance Co: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Policy or Claim#: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_

**MEDICAL HISTORY**

Have you ever had or do you currently have any of the following:

	Yes	No		Yes	No	Type
High or Low Blood Pressure	_____	_____	Arthritis	_____	_____	_____
Heart Disease	_____	_____	Asthma	_____	_____	
Heart Attack	_____	_____	Epilepsy	_____	_____	
Diabetes	_____	_____	Bone/Joint Surgery	_____	_____	
Circulation Problems	_____	_____	Any Spinal Surgery	_____	_____	
Joint Problems	_____	_____	Cardiovascular Condition	_____	_____	
Neurological Condition of the			Cancer	_____	_____	
Central Nervous System (CNS)			Chronic Lung Disease	_____	_____	
such as Parkinson's, CVA, MS, etc.	_____	_____	Depression/Anxiety	_____	_____	
Thyroid problems	_____	_____	Other _____			

If you've had surgery, please describe: \_\_\_\_\_

\_\_\_\_\_

Have you ever had similar problems? \_\_\_\_\_

If yes, please note previous treatments? \_\_\_\_\_

Which treatments helped? \_\_\_\_\_

Which treatments did not help, made worse? \_\_\_\_\_

On a scale of 0 to 10, what is your pain level? Now: \_\_\_\_\_ Best: \_\_\_\_\_ Worst: \_\_\_\_\_

Have you had a history of pain for more than three months? \_\_\_\_\_

Please list any current medications you are currently taking \_\_\_\_\_

\_\_\_\_\_

**CONSENT FOR TREATMENT**

I acknowledge that I have been referred to MCKEAN PHYSICAL THERAPY for physical therapy services and will be subjected to various therapeutic procedures. I understand that the prescribed treatments may take the form of moist heat, cold, ultrasound, electrical stimulation, traction, therapeutic exercise, soft tissue and joint mobilization, and other recognized procedures utilized by physical therapists. I hereby authorize my consent for Randall B. Schlosser, P.T. or other physical therapists in his employ to treat me as prescribed.

Signed: \_\_\_\_\_

**AUTHORIZATION FOR PAYMENT**

I acknowledge that I am financially responsible to MCKEAN PHYSICAL THERAPY for any debts not covered by third party payers which are incurred during the period of time in which I am receiving treatment for my physical ailment as prescribed by my physician. Furthermore, should my third party payer not permit assignment of benefits, I understand that the payment for services rendered will come to my residence. I understand that it is my responsibility to sign the checkover to MCKEAN PHYSICAL THERAPY and agree to do so promptly.

Signed: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I authorize and direct MCKEAN PHYSICAL THERAPY to release information concerning my physical condition to insurance companies and other third party payers who are involved in processing claims for payment of treatments and administered by S.P.T. I also authorize the release of medical information concerning my physical condition to my employer, if I am being treated for a work related injury, and S.P.T. is on my employer's designated list of duly licensed practitioners of the healing arts. Medical information concerning my physical condition may also be released to my employer of other parties if S.P.T. is in receipt of my signed authorization from such other parties. I also authorize S.P.T. to obtain medical records from medical offices relating to my current treatment.

Signed: \_\_\_\_\_

I request that payment of authorized insurance benefits be made either to me or on my behalf for any services furnished me to MCKEAN PHYSICAL THERAPY. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits, or the benefits payable for related services.

Signed: \_\_\_\_\_



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