X-Cel Therapy Group
Patient Information

Date:_____

First Name:_____ **MI:**_____ **Last Name:**_____

Social Security Number: _____ **Gender:** Male Female **Date of Birth:** _____

Marital Status: Single Married Widow Divorced **Status:** Student Employed Retired

Mailing Address:_____ **Physical Address:**_____

City:_____ **State:**_____ **Zip:**_____

Home Phone #:_____ **Cell Phone #:**_____

Was condition related to: ( ) Employment ( ) Auto Accident ( ) Other_____

Date condition / Accident began:_____

Referring Physician:_____ **Next Appointment:**_____

Family Physician:_____

Employer:_____ **Employer Phone #:**_____

PRIMARY INSURED'S INFORMATION

(This is the person, if different from the patient, whose name appears on your insurance card. If more than one name appears on the insurance card, the primary or first person named on the card.)

Name:_____ **Address:**_____

City:_____ **State:**_____ **Zip:**_____

Relationship to Patient:_____ **SS #:**_____ **Date of Birth:**_____
(month/day/year)

Please provide contact information where someone can be reached in case of EMERGENCY while patient is receiving therapy

Name:_____ **Relationship:**_____ **Phone Number:** _____

Is this an emergency contact? Y N
Is this person permitted to discuss your medical information? Y N

ARE YOU CURRENTLY RECEIVING HOME HEATLH SERVICES? ( ) YES ( ) NO

(Home Health Service includes any medical care or assistance by a nurse or doctor or therapist in your home.)

Have you received physical therapy for this condition before? ( ) Yes ( ) No

Please tell us how you heard about X-Cel Therapy Group?

Radio Ad___ Newspaper Ad ___ Physician ___ Friend ___ Other _____

Medical History

Name: _____ **Date:** _____

Existing or Relevant Previous Conditions

Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinsons	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High/Low Blood Pressure	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No		

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Fall History

Injury as a result of a fall in the past year? ◯ Yes ◯ No
Two or more falls in the last year? ◯ Yes ◯ No
Patient is at risk for falls? ◯ Yes ◯ No

Surgical History

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

- ☐ **Currently not taking any medications**
- ☐ **Are you pregnant**
- ☐ **Do you have a pacemaker**

X-Cel Therapy Group
Functional Activities

Patient's Name: _____ Date: _____

Functional Activity	No Difficulty	Minimal Difficulty	Moderate Difficulty	Maximal Difficulty
1. Sitting	_____	_____	_____	_____
2. Standing	_____	_____	_____	_____
3. Walking in the Home	_____	_____	_____	_____
4. Walking in the Neighborhood	_____	_____	_____	_____
5. Using Stairs	_____	_____	_____	_____
6. Driving	_____	_____	_____	_____
7. Getting in/out of Car	_____	_____	_____	_____
8. Shopping	_____	_____	_____	_____
9. Rolling in Bed	_____	_____	_____	_____
10. Bathing	_____	_____	_____	_____
11. Grooming	_____	_____	_____	_____
12. Getting Dressed	_____	_____	_____	_____
13. Preparing food/Cooking	_____	_____	_____	_____
14. Reaching	_____	_____	_____	_____
15. Lifting/Carrying _____#	_____	_____	_____	_____

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DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one, or all, of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____
Patient Name

_____
Patient Signature

_____
Date