

**KAPPER PHYSICAL THERAPY**  
**604 CENTER PARKWAY, SUITE A**  
**YORKVILLE, IL 60560**  
**PHONE: (630) 553-8414, FAX: (630) 553-8415**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Phone(Home) \_\_\_\_\_ (Work) \_\_\_\_\_ Social Sec. # \_\_\_\_\_  
Marital Status S M D W  
Spouse or Parent's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Social Security # (if they are the insured) \_\_\_\_\_  
Employer's Name \_\_\_\_\_  
Employer's Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_  
Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Physician's Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

**INSURANCE INFORMATION**

Name of Insured \_\_\_\_\_  
Policy # \_\_\_\_\_  
Group # \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Phone \_\_\_\_\_

Please provide us with any supplemental insurance info.  
If your insurance company requires a special form please  
provide this for us. -Thank you-

**WORKER'S COMP CLAIMS**

Date of Injury \_\_\_\_\_  
Claim# \_\_\_\_\_  
Send claim to: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Attn: \_\_\_\_\_

----- PAYMENT AT TIME OF SERVICE IS APPRECIATED -----

**ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION**

I understand and agree that regardless of insurance status, I am ultimately financially responsible for full payment for services rendered to me or my dependents in this office. In addition, any unpaid balance after 90 days will be subject to interest charges of 1 ½% per month, minimum of \$2.50.

I hereby authorize KAPPER PHYSICAL THERAPY to obtain or release all requested health information regarding care and treatment of myself or my dependents from/to insurance agencies and medical professional persons. I also authorize payment directly to the above named physical therapy clinic of the medical and /or dental plan otherwise payable to me.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I also authorize release of above mentioned information and payment to my secondary insurance company.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**HISTORY FORM**

Please provide us with the important background information on the following form. All information is considered confidential and will be released only to your physician unless prior written authorization is given. Thank you.

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

**How did you hear about us?**

- Doctors referral       Insurance       Yellow Pages       Newspaper
- Friend       OurWeb Site       Previous patient       Other \_\_\_\_\_

**Are you currently seeing any of the following for your condition?**

- |     |    |                |     |    |                           |
|-----|----|----------------|-----|----|---------------------------|
| YES | NO | Medical Doctor | YES | NO | Psychiatrist/Psychologist |
| YES | NO | Osteopath      | YES | NO | Physical Therapist        |
| YES | NO | Dentist        | YES | NO | Chiropractor              |
| YES | NO | Attorney       | YES | NO | Massage Therapist         |

**Have you ever been diagnosed with any of the following conditions?**

- |     |    |                                  |     |    |                                      |
|-----|----|----------------------------------|-----|----|--------------------------------------|
| YES | NO | Cancer. If yes, what kind: _____ | YES | NO | Rheumatoid Arthritis                 |
| YES | NO | Heart Problems                   | YES | NO | Other arthritis                      |
| YES | NO | Circulation Problems             | YES | NO | Hepatitis                            |
| YES | NO | High Blood Pressure              | YES | NO | Tuberculosis                         |
| YES | NO | Asthma                           | YES | NO | Stroke                               |
| YES | NO | Emphysema/Bronchitis             | YES | NO | Kidney Disease                       |
| YES | NO | Chemical Dependency              | YES | NO | Anemia                               |
| YES | NO | Thyroid Problems                 | YES | NO | Epilepsy/Seizures                    |
| YES | NO | Diabetes                         | YES | NO | Depression                           |
| YES | NO | Multiple Sclerosis               | YES | NO | Osteoporosis                         |
| YES | NO | Prostate Problems                | YES | NO | Pregnancy (Currently/<br>Past 1 yr.) |
| YES | NO | Other _____                      |     |    |                                      |

**Please list any injuries, surgeries or other conditions** for which you have been treated or hospitalized (including fractures, dislocation, sprains) within the last few years, including the approximate date of the procedure.

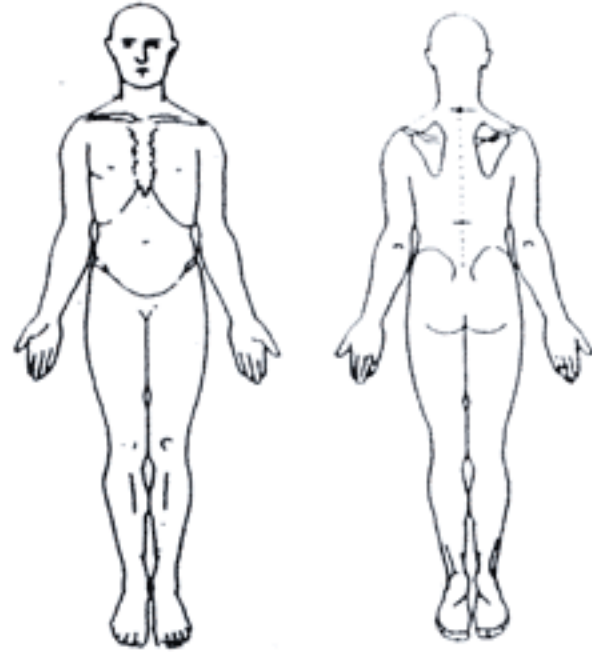
<u>DATE</u>	<u>INJURY/SURGERY/HOSPITALIZATION</u>
_____	_____
_____	_____
_____	_____

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Please rate the severity of the symptoms/pain you are currently experiencing by circling the appropriate number.

	No Pain	Excruciating
• Currently, as you fill out this form	0 1 2 3 4 5 6 7 8 9 10	
• At your best in the past 2 weeks	0 1 2 3 4 5 6 7 8 9 10	
• At your worst in the past 2 weeks	0 1 2 3 4 5 6 7 8 9 10	

Mark your present symptoms on the Body Chart.



List any activities you have difficulty performing as a result of your current problem.

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List any PRESCRIPTION or OVER THE COUNTER medications you are taking.

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Have you been seen by a home health agency in the last 60 days? YES NO

Is there any other information you feel is important to your care?

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Form reviewed with patient? YES NO

DATE \_\_\_\_\_ PT Signature \_\_\_\_\_