Thanks for choosing…

STARKVILLE PT

Yes	No	
☐	☐	Have you had HOME HEALTH in the past month? If yes, where?_____
☐	☐	Are you on an HMO rather than Medicare? (ex. SecureHorizons, Pyramid, etc.)
☐	☐	Do you have a secondary insurance?
☐	☐	Do you or do you plan to have an attorney involved?
☐	☐	Have you had a MRI related to the diagnosis we are about to treat? If yes, where?_____
☐	☐	Do you have a follow up appointment with your primary care physician or the physician that sent you here? If yes, what doctor?_____ When?_____

Do you have any other medical conditions that we need to be aware of? Please list all other medical conditions, including high blood pressure, diabetes, allergies that may affect your experience with physical therapy: _____

_____

_____

_____

Do you have any drug allergies? If yes, please list them here:

_____

Is there another doctor you would like us to send your physical therapy information to besides the one who referred you to us? If yes, please list here: _____

_____