



**Timberlane**  
PHYSICAL THERAPY

WELCOME TO OUR PRACTICE

321 Main Street, Suite D  
Winooski, VT 05404

40 Timber Lane  
South Burlington, VT 05403

Patient Name: \_\_\_\_\_ (E-mail) \_\_\_\_\_

Address: (Not P.O. or RR) \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Day/Work Phone: (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: F M Marital Status \_\_\_\_\_ Student: Y or N

Social Security number: \_\_\_\_\_

Who do we contact in case of an emergency? \_\_\_\_\_

Phone number: \_\_\_\_\_

Referring Physician \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

By my signature below, I acknowledge that any appointment that needs to be cancelled must be done with **24 hours notice**. If I fail to give the appropriate notice, I may be charged for a broken appointment. Broken appointment charges are not billable to my insurance company and **are my responsibility**.

Any balance over 90 days becomes my responsibility regardless of the insurance status.

\_\_\_\_\_  
(Signature of Patient or if a minor Signature of Parent or Guardian) Date

I give my permission to be treated by Timberlane Physical Therapy. I further authorize Timberlane Physical Therapy to bill my Insurance Company for payment to be made directly to Timberlane Physical Therapy for services on my behalf.

\_\_\_\_\_  
(Signature of patient or if a minor Signature of Parent or Guardian) (Date)

Name: \_\_\_\_\_  
 Age: \_\_\_\_\_ Sex: \_\_\_\_\_ D.O.B. \_\_\_\_\_  
 Referring Physician: \_\_\_\_\_



**Medical History**

Do you have (or have you experienced) any of the following:

High blood pressure	Y	N	History of cancer	Y	N
Heart disease	Y	N	Osteoporosis	Y	N
Angina (chest pain)	Y	N	Severe Headaches	Y	N
Shortness of breath	Y	N	History of fractures	Y	N
Lung Disease	Y	N	Thyroid condition	Y	N
Recent weight loss/gain	Y	N	Unusual joint pain or swelling	Y	N
Heartburn (stomach upset)	Y	N	A known psychological disorder	Y	N
Diabetes	Y	N	Current fever or systemic infection	Y	N
Low blood sugar	Y	N	Problems with or history of Alcoholism	Y	N
Urinary incontinence	Y	N	Any blood or bleeding disorders	Y	N
Impaired vision	Y	N	Are you HIV positive	Y	N
Impaired Hearing	Y	N	Are you latex sensitive	Y	N
Any signs or history of a neurological disorder (CP, stroke, Parkinsons)				Y	N

**OB/GYN**

**PAIN/SWELLING LOCATION:**

Have you had any complicated pregnancies	Y	N		
Do you have abnormal menstrual cycles	Y	N		
Have you had pelvic inflammatory disease	Y	N		
Are you pregnant	Y	N		
Are you more than 6 months post-partum and post-weaning			Y	N

Please list all medications and the reason for taking them:

	medication	reason
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Do you have any known allergies? If yes, please list: \_\_\_\_\_

Please list all surgeries and approximate dates: \_\_\_\_\_

Please list all diagnostic tests for the injury/condition you are receiving treatment for: \_\_\_\_\_

Have you seen anyone else for this injury/condition? If yes, please list: \_\_\_\_\_

How did you find out about Timberlane Physical Therapy? \_\_\_\_\_

The purpose of this questionnaire is to assist us in providing you quality care by obtaining a better understanding of your total status. We appreciate your completion of this questionnaire. Your therapist will answer any questions during your initial visit. This questionnaire will be part of your confidential medical record.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Primary Insurance Carrier:

Insurance Company \_\_\_\_\_

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

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

Group Number \_\_\_\_\_ Certificate Number \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Policy Holder's SS# \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer of Policy Holder \_\_\_\_\_

Relationship to Patient: Spouse Parent Other (Please circle one)

Is this condition related to: Employment: \_\_\_ Date of Injury: \_\_\_\_\_

Motor Vehicle Accident \_\_\_\_\_ Date of Injury \_\_\_\_\_ State \_\_\_\_\_

Other Accident \_\_\_\_\_ Date of Injury \_\_\_\_\_

Secondary Insurance Carrier

Insurance Company \_\_\_\_\_

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

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

Group Number \_\_\_\_\_ Certificate Number \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_

Policy Holder's SS# \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer of Policy Holder \_\_\_\_\_

Relationship to Patient: Spouse Parent Other (Please circle one)