PINNACLE MEDICAL GROUP
Therapy & Wellness Center
4110 Manatee Ave. W., Bradenton, FL 34205
941-748-8383

PATIENT MEDICAL HISTORY

Patient Name:________________________ Date of Birth ____________ SS#______________

Address: ____

City:________________________ State:____________ Zip: ____________

Home Phone: ______________ Work Phone:______________ Marital Status: ❑ Married ❑ Single

Email:______________________________ Gender: ❑ Male ❑ Female

Ethnicity:________________ Preferred Language: ______________________

Race: ❑ American Indian or Alaska Native ❑ Black or African American ❑ Asian
❑ Native Hawaiian or Other Pacific Islander ❑ Unreported/Refused to Report ❑ White

Emergency Contact:____________ Phone:______________ Relationship:______________

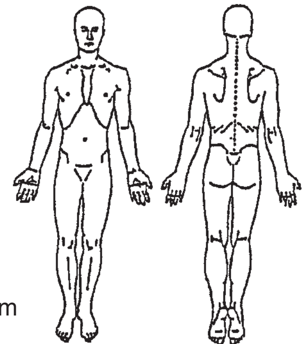
Reason for Therapy:__________________________ Date of Onset: ____________

Please report any previous therapy including place and dates:

____

____

____



Please describe your pain scale: “0” is no pain “10” is Worst possible pain

Today:_______ Worst in last 30 days _________ Least in last 30 days _______

Please “X” the area of your problem in the diagram

Please list any X-Rays, MRIs, or testing you have had done, including date if possible: ____________________

____

Please list any medications you are taking:____________________________

____

Is this services for treatment related to a work injury? _____ Yes _____ No

Is this service for treatment related to a motor vehicle accident? _____ Yes _____ No

Medicare will not pay for concurrent home health and outpatient therapy services.

Are you currently receiving home health services? _____ Yes _____ No

If yes, Name of Agency:________________Home Health Agency Phone Number: ____________

Have you been discharged from home health within the last 30 days? _____ Yes _____ No

Home health start date:____________ Home health discharge date:______________

Please circle any medical conditions you have:

Allergies	Arthritis	Asthma	Cancer	Chest pain	Chronic bronchitis	Diabetes
Dizziness	Emphysema	Heart disease	Heart attack	Hepatitis	High blood pressure	Hypoglycemia
IBS	Kidney problems	Liver disease	Parkinson’s	Pheumonia	Polio	Rheumatic fever
Ringing in ears	Shortness of breath	Stroke	Ulcers	Urinary tract infection		Pregnancy

Other: ______________________________________

I hereby authorize my consent for treatment.

Signature:______________________________ Date: ______________

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Patient Consent to Receive Mail, Telephone and/or E-mail Message

____ DOB: ______________

Please print (Last Name) (First Name) (M.I.)

Do we have permission to?

Send a yearly appointment card to your home? Yes ❑ No ❑

Send test results to your home? Yes ❑ No ❑

Send test results to your email? Yes ❑ No ❑

Email address: ______________________________

Leave the following information on your home answering machine/voice mail/email:

Appointment information Yes ❑ No ❑

Billing information Yes ❑ No ❑

Medical information Yes ❑ No ❑

Leave the following information on your work answering machine/voice mail:

Appointment information Yes ❑ No ❑

Billing information Yes ❑ No ❑

Medical information Yes ❑ No ❑

I give permission to share appointment information with the person named below:

Name: ______________________________

I give permission to share medical information (including biopsy/lab results, prescriptions, etc.) with the person(s) listed below:

Name: ______________________________

Name: ______________________________

I give permission to share billing information with the person listed below:

Name: ______________________________

Signature of Patient: ______________________________ Dale: ______________

For internal purposes only - Account No:

PT-B 8/11