Andrus Physical Therapy
232 Norwood Avenue Suite 1C
West Long Branch, NJ 07764
Phone: (732) 923-1500 Fax: (732) 923-1510

MEDICAL HISTORY

Name:_______________________________________ SS#___________________________

Home Address:____

City:________________________________ State:_______ Zip:________________________

Home Phone:___________________________ Work Phone: __________________________

Sex:______ M ______ F Marital Status:___________Date of Birth:__________ Age: _____

Please describe the condition for which you are seeking Physical Therapy:________________
____

Do you have any history of or currently experiencing any of the following conditions, please check off the appropriate box:

Blood Pressure		**Rheumatoid Arthritis**		**Osteoporosis**	
Heart Attack		**Osteoarthritis**		**Kidney Disorders**	
If yes, what age?		**Epilepsy**		**Diabetes**	
High Cholesterol		**Seizures**		**Migraine Headaches**	
Heart Murmur		**Multiple Sclerosis**		**TMJ**	
Lung Disease		**Stroke**		**Cancer**	
Asthma		**If yes, what age?**		**If yes, what type?**	
Hepatitis		**Parkinson’s**			

Please list any operations in the last five years:____
____

Allergies:____

Medications you are currently taking:____
____

Are you currently or have you recently experienced any of the following:

Pain		**Back and/or Neck Pain**		**Shortness of Breath**	
Palpitation		**Swollen, Stiff or Painful Joints**		**Fainting, Dizziness or Black Outs**	

Has a doctor or any health care provider ever restrict you from participating in any exercise program and/or sport? If yes, for what reason?____

Are you currently or attempting to become pregnant? ________Yes ________No ________Does not apply

Are you currently involved in any recreational or competitive exercise/sport? If yes what type?
____

What is your occupation?____

Andrus Physical Therapy
232 Norwood Avenue Suite 1C
West Long Branch, NJ 07764
Phone: (732) 923-1500 Fax: (732) 923-1510

IN CASE OF EMERGENCY, PLEASE PROVIDE A CONTACT PERSON:

Name:____________________________________ Relationship:_______________________________

Home phone: ______________________________Work or other phone:________________________

INSURANCE INFORMATION

Primary Insurance Company:____

Policy Holder Name (if different from patient's)____

Policy Holder Date of Birth:____

Secondary Insurance Company:____

Policy Holder Name (if different from patient's):____

Policy Holder Date of Birth:____

MOTOR VEHICLE OR WORKMANS COMPENSATION
Please fill out the following information if your claim involves a motor vehicle accident or workman's compensation claim.

Insurance Company Name:______________________________ Phone#___________________________

Date of Accident/Injury:____

Claim #________________________ Case Manager Name______________________________________

I HAVE READ THE ABOVE STATEMENTS AND HAVE ANSWERED THEM TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT I AM RESPONSIBLE TO IMMEDIATELY NOTIFY Andrus Physical Therapy, LLC OF ANY CHANGE(S) IN MY MEDICAL HISTORY, MEDICATIONS, PERSONAL INFORMATION INSURANCE COVERAGE. I ALSO UNDERSTAND THAT INSURANCE COVERAGE AND/OR AUTHORIZATION DOES NOT GUARANTEE PAYMENT OF SERVICES. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE COMPANY. .

Signature of patient or responsible party:_______________________________Date:_______________