CHPT
Complete Hometown Physical Therapy

201A North Main St, Hallettsville, TX 77964 (361) 798-3500
105 Boehm Dr, Shiner, TX 77984 (361) 594-8301
206 Hwy 77A South, Yoakum, TX 77995 (361) 407-5091
www.completehometownpt.com

Patient Demographic Sheet

Patient Name: _____ **Gender** _____

Date of Birth _____ **Age** _____

Name of Person Completing Form _____

Phone # _____

Mailing Address _____

City _____ **State** _____ **Zip** _____

Diagnosis (if any, please list diagnostic codes if you know it) _____

_____

Occupation: _____

Highest grade, diploma, or degree earned: _____

Spouse or Caregiver Name _____ **Relationship** _____

Address (if different than patient) _____

_____

Phone #1 _____ **Home / Cell / Work**

Phone #2 _____ **Home / Cell / Work**

Email address _____

Primary Language(s) Spoken: English Spanish Other_____

List any children or important family members and their ages:

_____

_____

_____

REASON FOR REFERRAL/PRIMARY REASON FOR SEEKING THERAPY:

_____

_____

_____

_____

Please describe YOUR vision, goals, and/or expectations for therapy.

_____

_____

_____

_____

- Please try to provide at least 24 hours notice if you must cancel or reschedule an appointment so that we may provide another patient with that appointment opportunity. Exceptions are for Monday appointments when 24 hour notice is not possible or when your appointment is the day after a holiday.

- I hereby give authorization for payment of medical and/or auto insurance benefits and/or legal settlement payments to be made directly to Complete Hometown Physical Therapy, and for any assisting therapist employed by or contracted with Complete Hometown Physical Therapy.

- I understand that I am financially responsible for all charges, whether or not they are covered by my insurance, provided I am notified in advance that any proposed service or therapy/treatment/procedure may not be covered by patient's insurance provider(s).

- I understand that all copay, coinsurance and deductible amounts are due and payable at the time of service, unless a payment arrangement has been made with the billing. If the explanation of benefits from the insurer(s) shows a remaining patient balance due, the patient will be billed accordingly.

- In the event of a default in payment, the prevailing party in any lawsuit or mediation will be entitled to recover reasonable attorney fees and actual costs of collection.

- I hereby authorize Complete Hometown Physical Therapy to release any and all information necessary to secure payment of benefits to only those parties legally entitled to receive information for purposes of receiving payment of existing balances or for authorization for continuation of services as may be necessary or requested by the patient's insurer(s).

- I agree that a photocopy of this agreement shall be as valid as the original.

Thank you for you cooperation.

Patient (if minor – Parent or Legal Guardian) Signature: _____

Date: _____

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Patient Medical History

Name: _____

PRIOR TREATMENT INFORMATION

Have you ever had speech, physical or occupational therapy prior to this evaluation? _____

If yes, please mark all that apply ☐ speech therapy ☐ physical therapy ☐ occupational therapy

How long did you receive therapy? _____

When did you receive therapy? _____

Where did you receive therapy? _____

COMMUNICATION

Do you (or the patient) notice a change or have difficulties with…? (Please mark all that apply.)

☐ Difficulty finding words/names
☐ Difficulty forming sentences
☐ Difficulty understanding others
☐ Change in quality of voice
☐ Change in voice pitch
☐ Difficulty coordinating voice, tongue, lips, etc. for speech
☐ Shortness of breath when talking
☐ Stuttering/dysfluency
☐ Others find you difficult to understand
☐ Change in volume of speech
☐ Difficulty pronouncing specific sounds
☐ Difficulty moderating social skills

How long have you had these concerns (onset):_____

What situation(s) are you at your best? _____

What situation(s) do you experience the most difficulty? _____

Please explain any other communication concerns.

_____

_____

What is the best way you learn new things?

☐ Written instruction ☐ Demonstration ☐ Verbal instruction ☐ Hands-on learning

FEEDING/SWALLOWING

Do you have any concerns about eating/swallowing? Please mark all that apply:

☐ clearing food/liquid from mouth
☐ chewing food
☐ choking
☐ wet/gurgly voice quality
☐ constant throat clearing
☐ gagging/vomiting
☐ coughing
☐ increased meal times
☐ drooling
☐ history of aspiration
☐ history of tube feedings
☐ history of reflux
☐ limited diet
☐ frequent upper respiratory infections

Please explain any other concerns.

_____

_____

MEDICAL HISTORY

Please mark all that apply:

☐ stroke
☐ memory impairment
☐ Dementia
☐ head injury
☐ dizziness/headaches
☐ seizures
☐ Parkinson's Disease
☐ asthma

Please explain any of the items checked above (i.e. age of incident, complications, etc.)

_____

_____

Please list your doctor(s):

Name: _____ Specialty _____ Phone #_____

Name: _____ Specialty _____ Phone #_____

MEDICATIONS

Medication:	How often do you take this medication?	Why do you take the medication?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have vision problems? If yes, please explain. _____

_____

Last vision screen (month/year) _____ **Results:** ☐ **normal** ☐ **abnormal** ☐ **other**_____

Do you wear glasses/contacts? _____

Do you have hearing problems? If yes, please explain. _____

_____

Last hearing screen (month/year) _____ **Results:** ☐ **normal** ☐ **abnormal** ☐ **other**_____

Do you use hearing aid/cochlear implant?_____

Does you use any other adaptive equipment? If yes, please explain. _____

_____

Does you have any dental problems? If yes, please explain. _____

_____ **Last dental cleaning (month/year)** _____

Surgeries/Hospitalizations/Visits to the Emergency Room:

Month/Year:	**Reason:**	**Length of Stay:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____

SIGNATURE OF PERSON ANSWERING QUESTIONS **DATE**

_____

RELATIONSHIP TO PATIENT