

 $\hfill\Box$ 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			
Name of Person Completing Form _			
Phone #			
Mailing Address			
City	State	Zip	
Diagnosis (if any, please list diagnostic	c codes if you know it)		
Occupation:			
Highest grade, diploma, or degree earne	ed:		
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	h Spanish O	ther	
List any children or important fa	mily members and their	ages:	

REASON FOR REFERRAL/PRIMARY REASON FOR SEEKING THERAPY:	
	•
	-
Please describe YOUR vision, goals, and/or expectations for therapy.	
	•
	=
	_
	•

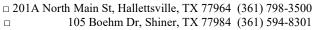
- Please try to provide at least 24 hours notice if you must cancel or reschedule an appointment so that we may provide another patient with that appointment opportunity. Exceptions are for Monday appointments when 24 hour notice is not possible or when your appointment is the day after a holiday.
-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

Date:

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





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Patient Medical History

PRIOR TREATMENT IN	NFORMATION		
Have you ever had speech, physical or occupational therapy pri	ior to this evaluation?		
If yes, please mark all that apply speech therapy	_ physical therapyoccupational therapy		
How long did you receive therapy?			
When did you receive therapy?			
Where did you receive therapy?			
COMMUNICATE Do you (on the notion) notice a change or have diffi-			
Do you (or the patient) notice a change or have difficulty finding words/names	, <u> </u>		
Difficulty forming sentences	Shortness of breath when talking Stuttering/dysfluency		
Difficulty understanding others	Others find you difficult to understand		
Change in quality of voice	Others find you difficult to understandChange in volume of speech		
Change in voice pitch	Difficulty pronouncing specific sounds		
Difficulty coordinating voice, tongue, lips, etc. for speech	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.			

FEEDING/SWALLOWING

Do you have any concerns about	eating/swallowing? Please mark a	all that apply:		
clearing food/liquid from mou	uth chewing fo	od	choking	
wet/gurgly voice quality	constant th	roat clearing	gagging/vomiting	
coughing	increased r	neal times	drooling history of reflux	
history of aspiration	history of t	ube feedings		
limited diet	frequent up	oper respiratory infections		
Please explain any other concerns	s.			
Please mark all that apply:	MEDICAL HIST	ORY		
stroke	memory impairment	Dementia	head injury	
dizziness/headaches	seizures	Parkinson's Diseas	se asthma	
Please list your doctor(s):				
Name:	Specialty	PI	none #	
Name:	Specialty	PI	none #	
	MEDICATIO	NS		
Medication:	How often do you take this medication?	the med	o you take dication?	

Do you have vision problems? If yes,	, please explain.		
Last vision screen (month/year)	Results:	normalabno	ormal other
Do you wear glasses/contacts?			
Do you have hearing problems? If yo	es, please explain.		
Last hearing screen (month/year)	Results: _	normalabno	rmalother
Do you use hearing aid/cochlear imp	olant?		
Does you use any other adaptive equ	ipment? If yes, please exp	lain	
Does you have any dental problems?	If yes, please explain.		
		Last dental cleani	ing (month/year)
Surgeries/Hospitalizations/Visits to t Month/Year:	the Emergency Room: Reason:		Length of Stay:
SIGNATURE OF PERSON ANSWI	ERING QUESTIONS	1	DATE
RELATIONSHIP TO PATIENT			