Physical Therapy for women
Lymphedema & Pelvic Rehab Center
Personalized, Compassionate Care

Thank you for choosing Physical Therapy for Women!

Jennifer R. Shepherd, PT, CLT-LANA
Karen Moore, PT, CDN • Amanda Knauff, DPT, CLT-LANA
Jennifer Guardino, MSPT, CLT, CIDN • Emily Wineinger, DPT
Brittany Reed, DPT, CLT • Taylor Ellis, DPT • Jordan Rackley, PT, DPT, OCS
Alexandra Richards, PT, DPT • Michele Hardee, PTA • Jolea Myles, PTA

Date_____

Patient Name: _____
(First) (Middle) (Last)

Nickname: _____

Date of Birth: _____ **Height:** _____ **Weight:** _____

Address: _____
(Street)

_____
(City) (State) (Zip code)

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Which is your primary phone? _____

Would you like to receive appointment reminders: _____

If yes, by text, voice or email _____* **Note that PTFW does not encrypt emails**

Work Status: (circle one) Full time Part time Retired Disability Not Employed

Employer: _____

Student Status: (circle one) Not a student Full-time Student Part-time Student

Marital Status: (circle one) Married Single Widowed Other

Email address: _____

Would you like to be added to our email list? _____

Emergency Contact: _____
(Name) (Phone #)

Relationship to patient: _____

Referring Physician: _____

Return to Dr. Date: _____

Reason for PT evaluation: _____ **Date of first symptom**_____

Primary Insurance_____ **Secondary Insurance** _____

IMPORTANT: If you are currently receiving home health care , physical therapy, or chiropractic care, or have received physical therapy for any diagnosis this year, please let us know. This may affect your insurance coverage.

Please Check and sign below:

☐ I am not currently receiving home health care, physical therapy, occupational therapy, speech therapy or chiropractic care for any other diagnosis.

****From the list above which type of care are you currently receiving?

_____

☐ I have read and understand the financial policy given to me by *Physical Therapy for Women, Inc.*

☐ I have read and understand the HIPAA Form.

☐ **MEDICARE PATIENTS** - Have you received physical therapy this year? If YES – How many visits did you attend? _____

_____

Patient signature (for all items above) **Date**

☐ I would like a copy of *Physical Therapy for Women, Inc's* Financial Policy and/or the HIPAA Form.

☐ I authorize Physical Therapy for Women, Inc. to use my photographic image in marketing materials advertising our services that will be viewed by the general public. This includes PTFW's website, FaceBook page, and printed marketing materials.

I have read and agree with the above statement.

_____

Signature **Date**

Physical Therapy for Women
Lymphedema and Pelvic Rehab Center
1630 Military Cutoff Road Suite 110
Wilmington, NC 28403
(910)798-2318

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Patient Name: _____

DOB: _____

List of Current Medications

Name of Medication	Dosage	Frequency	Route

Allergies:_____

_____

Patient Signature_____

Date_____