



Beth Shelly PT  
1634 Avenue of the Cities  
Moline, IL 61265  
563-940-2481 cell phone  
866-761-7464 fax

**NEW PATIENT INFORMATION:**

Today's Date: \_\_\_\_\_

Patient's Full Legal Name – please provide a copy of your driver's license or other photo identification  
Please complete all sections – print carefully in BLACK ink, Thanks

\_\_\_\_\_  
Last First Middle Initial Sex: Male \_\_\_ Female \_\_\_

Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Place a \* on the preferred phone number  
Cell Phone ( ) \_\_\_\_\_ email : \_\_\_\_\_

Patient Status: (check one) Single: \_\_\_ Married: \_\_\_ Other: \_\_\_  
Employment Status: (check one) Employed: \_\_\_ Retired: \_\_\_ Full-time student: \_\_\_ At home mom \_\_\_

Employer's Name and address \_\_\_\_\_

Referring Physician \_\_\_\_\_ Physician Phone number \_\_\_\_\_

Physician address \_\_\_\_\_

Reason for seeking Physical Therapy (Diagnosis) \_\_\_\_\_

**INSURANCE INFORMATION**

Primary insurance company \_\_\_\_\_ Insurance phone number \_\_\_\_\_

Policy number \_\_\_\_\_ Group number \_\_\_\_\_

Please provide a copy of your insurance card at the time of your first visit

Insured name: \_\_\_\_\_ Insured's Birthday \_\_\_\_\_

Employer Providing Primary Insurance: \_\_\_\_\_

Relationship to Patient: Self \_\_\_ Spouse \_\_\_ Parent \_\_\_

If you have Medicare Primary  
Secondary insurance name \_\_\_\_\_

Secondary insurance policy number \_\_\_\_\_

Medical history

Please give a brief description of the condition you are coming to physical therapy about.

How did it start? When did it begin?

\_\_\_\_\_

Is your condition: Getting worse \_\_\_\_\_ Getting better \_\_\_\_\_ Staying the same \_\_\_\_\_

Past treatment or tests for this condition: \_\_\_\_\_

What are your goals for therapy? \_\_\_\_\_

Current medications:

Name of drug	Reason for taking it	Name of drug	Reason for taking it
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		Continue on back if needed	

Allergies: Latex \_\_\_\_\_ Rubbing alcohol: \_\_\_\_\_ Other: \_\_\_\_\_

Please check all that apply:

Heart disease	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Scoliosis (curve of the spine)	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	Thyroid condition	<input type="checkbox"/>	Back / neck pain	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	Parkinson's / Alzheimer's	<input type="checkbox"/>	Broken bones	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>
Lung disease, asthma	<input type="checkbox"/>	Mental illness	<input type="checkbox"/>	Difficulty urinating in public	<input type="checkbox"/>
Chronic coughing	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	Irritable bowel syndrome	<input type="checkbox"/>
TB	<input type="checkbox"/>	Urinary or fecal leakage	<input type="checkbox"/>	Family history of cancer	<input type="checkbox"/>
Sexual transmitted disease	<input type="checkbox"/>	Painful intercourse	<input type="checkbox"/>	Others, please list:	<input type="checkbox"/>
HIV / AIDS	<input type="checkbox"/>	Sexual abuse	<input type="checkbox"/>		<input type="checkbox"/>

Covid infection date(s) \_\_\_\_\_ Long lasting covid symptoms

Fever	<input type="checkbox"/>	Dizziness or faintness	<input type="checkbox"/>	Sweats	<input type="checkbox"/>
Nausea and vomiting	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Night pain	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	Weight loss	<input type="checkbox"/>		<input type="checkbox"/>

Please list all surgeries: \_\_\_\_\_

Social history

Do you live: Alone \_\_\_\_\_ With a spouse \_\_\_\_\_ With others \_\_\_\_\_

Number of children living with you: \_\_\_\_\_ Ages \_\_\_\_\_

Do exercise on a regular basis? What type? \_\_\_\_\_

Amount of stress(circle one): At home      low      medium      high  
At work      low      medium      high

Do you feel safe in your home? \_\_\_\_\_

Please list any person you would allow information to be shared with (spouse, son / daughter, friend)

Is there any other history you would like to tell me about?

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

Privacy Act: I authorize Beth Shelly PT to release medical or other information necessary to provide my treatment and process the claim. I understand this information will not be shared unnecessarily and that my personal information is protected under the Privacy act which this office abides by. A copy of office HIPPA policy is available on line or a printed copy will be provided on request. Please ask Beth if a copy is needed. Please list any person you would allow information to be shared with (spouse, son / daughter, friend) \_\_\_\_\_

Patient Initials: \_\_\_\_\_

Consent to treat: I consent to physical therapy services at Beth Shelly PT. In doing so, I understand that such therapy may involve bodily contact, touching and / or direct contact of a sensitive nature. I understand that these procedures will be fully explained before they are provided and that I have the right to refuse or stop any treatment at any time without fear of judgment or other repercussions.

Patient Initials: \_\_\_\_\_

Attendance policy: Your success in PT is dependent on regular attendance in therapy. I often have a waiting list of patients needing therapy. Please provide 24 hour notice if you are unable to attend. This gives me time to call those on the waiting list. Failed appointments or those cancelled after 24 hours will be charged a **\$50 cancellation fee**. Repeated failures to attend will result in re-evaluation of your need for therapy.

Emergencies or weather cancellations will not be charged the cancellation fee. Please help me to provide the best care possible for you and others. **Do not see two physical therapists in the same day.**

Patient Initials: \_\_\_\_\_

Statement of Understanding - Notice of Rights for Secure Communication and Waiver of Those Rights  
Federal law requires that this practice use secure/encrypted methods when texting or e-mailing patients. At this time, Beth Shelly PT does not offer a secure/encrypted method to communicate electronically with patients. However, I take patient confidentiality and legal compliance *very seriously*.

- My business phone is a cell phone. This also serves as my home phone.
- I am the only person using the phone, I have no secretary. Occasional you may receive a call from the billing company or my assistant, the phone will always be answered by me.
- I will not be able to answer the phone if I am working with a patient. Please leave a message with your name and phone number. My phone is password protected.
- When texting, also please make sure to include your name.
- Email is also fine, make sure your full name is included.
- At this time my email is not secure or encrypted.
- I will make every effort to respond to text, phone messages, and emails within 24 hours or the next business day. Please contact me again if I have not responded in 2 days.

These communications may or may not include private information (such as name, health condition, diagnosis, or billing/financial information). I understand the risks inherent in using unsecured/unencrypted communications. I acknowledge that I may change my preference below at any time by notifying the practice in writing.

Initial only those that apply

Please place \* on the preferred method of communication

I authorize this practice to contact me via unsecured text \_\_\_\_\_

I authorize this practice to contact me unencrypted email. \_\_\_\_\_

Please contact me only by phone \_\_\_\_\_

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_