IOWA STATE UNIVERSITY
PT & Sports Medicine at TSHC
PATIENT/STUDENT/ATHLETE QUESTIONNAIRE (Rev. 1/16)

*****Name: (Last, First) _____ ***** Birthdate: _____

*****Sex: M _____ F _____

*****Student/Faculty/Staff I.D. No.: _____

ISU Student ISU Athlete Faculty/Staff Other (Please circle one)

*****Address: _____

*****Local Phone: _____ ***** Work Phone: _____

*****Referring Physician: _____

*****Physician Address: Student Health Center _____ McFarland Clinic _____ Other _____

*****Date of Injury/Illness: _____ ***** Area of injury/illness: _____

If this a work related injury/illness? Yes: _____ No: _____

If yes, name of Employer & Address: _____

*****Do you have insurance to cover the cost of physical therapy services? Yes: _____ No: _____

*What is the name of your insurance company? _____
***If you have Wellmark/BCBS insurance, have you had any PT visits this calendar year?**

No___ Yes___. If yes, approximately how many? ___

***** Have you ever received physical therapy treatment before? Yes: ____ No: ____

When? _____ Where? _____

*****Do you have any of the following? If so, please circle:

Diabetes - Heart Disease - Metal Implants - Pacemaker - Pregnancy - Transmittable Disease

Allergies: _____

*******If you make additional appointments, you are expected to keep them. Failure to do so may result in your being discharged from physical therapy and also may prevent another patient/athlete from receiving treatment. If for some reason you will not be able to keep your appointment, you are expected to call and cancel that appointment ahead of time by calling 294-2626. Thank you for your consideration.*******

*****Signed: _____ *****Date: _____