Lexington Medical Park
Otarre Pointe
Physical Therapy/Occupational Therapy

Lexington Medical Park Otarre Pointe
3799 12th Street Extension , Suite 100 • Cayce, SC 29033
Phone: (803) 926-6810 • **FAX:** (803) 926-6811

Lexington Medical Center

Patient History

Name: ______________________ ☐ Male ☐ Female **DOB:** ______________

Referring Physician: ______________________ **Date of next physician visit:** ______________

Date of injury: ______________________ **Are you currently working?** ☐ Yes ☐ No

Body part(s) being treated: ______________________

Have you had any of the following tests for this condition? ☐ MRI ☐ X-ray ☐ CAT scan ☐ Bone scan ☐ Other: ______________

Check which apply to your symptoms:

☐ Motor vehicle accident
☐ Work related accident
☐ Athletic/Recreational injury
☐ Recurrence of previous injury
☐ Injury related to falling
☐ Injury related to lifting
☐ Cause unknown
☐ Other: ______________

Have you had a related surgery/operation? ☐ Yes ☐ No If yes, date of surgery? ______________
Other surgeries (with dates):______________________

Please check if your have ever been diagnosed with any of the following:

☐ Asthma
☐ Cancer
☐ Diabetes
☐ Depression
☐ Difficulty hearing
☐ Dizziness
☐ Fibromyalgia /Chronic Fatigue Syndrome
☐ Hepatitis
☐ GI Problems
☐ High Blood Pressure
☐ Headaches
☐ Heart disease
☐ Kidney disease
☐ Liver disease
☐ Pacemaker/Defibrillator
☐ Respiratory problems
☐ Seizures
☐ Stroke / CVA
☐ Tuberculosis

Other: ______________________

Is there any other information regarding your past medical history we should know about? ☐ Yes ☐ No
If yes, please list/describe: ______________________

Medications (including injections) :
☐ I **am** taking medications (please list below **or** provide a copy to staff). ☐ I **am not** taking medications at this time.

______________ ______________ ______________
______________ ______________ ______________
______________ ______________ ______________
______________ ______________ ______________

Drug and/or Food Allergies: ______________________
Latex / Rubber/ Elastic Sensitivity: ☐ Yes ☐ No

Pain scale: Please circle number under a face below that best represents your pain level **currently**.
Location(s) of Pain: ______________________

0
NO HURT

1 - 2
HURTS
LITTLE BIT

3 - 4
HURTS
LITTLE MORE

5 - 6
HURTS
EVEN MORE

7 - 8
HURTS
WHOLE LOT

9 - 10
HURTS
WORST

Signature: ______________________ Date: ______________

If other than patient: ______________________ Relationship: ______________

CONTINUED ON OTHER SIDE

Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Not Employed ☐ Student ☐ Disabled ☐ Self Employed

Employer: ______________________________ Phone: ______________

Address: ______________________________ Zip: ______________

Insurance Card Holder:
Name: ______________________ SS#: ______________ DOB: __________

Responsible Party:
Name: ______________________ SS#: ______________ DOB: __________

Emergency Contact:
Name: ______________________ Relationship: ______________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Medicare patients only:

Retirement Date: ______________ Spouse's Retirement Date: ______________

1. Are benefits based on ☐ Age ☐ Disability or ☐ End-Staged Renal Disease? (Check all that apply)
2. Are you receiving black lung benefits? ☐ Yes ☐ No
3. Do you work? ☐ Yes ☐ No
4. Does your spouse work? ☐ Yes ☐ No
5. Are you covered by a family members insurance? ☐ Yes ☐ No
6. Is this visit related to ☐ work ☐ non-work ☐ auto accident or ☐ none of these? (Check one)

Self-pay patients only:

1. Have you applied for other health insurance? ☐ Yes ☐ No
2. Would you like any information on how to do so? ☐ Yes ☐ No
3. Would you like to speak with a Financial Counselor? ☐ Yes ☐ No