David Gilboe and Associates, Inc.
Physical Therapy & Occupational Therapy
(586) 779-8892

PATIENT INFORMATION SHEET

Form Revised: 11/18/2026

PATIENT NAME: _____ DATE OF BIRTH:_____

SOCIAL SECURITY NUMBER: _____ AGE: _____ SEX: ☐ Male ☐ Female

MARITAL STATUS: ☐ S ☐ M ☐ W ☐ D EMAIL ADDRESS: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (____) _____ CELL PHONE: (____) _____

WOULD YOU LIKE TO RECEIVE APPOINTMENT REMINDERS? IF YES, CHOOSE: ☐ Phone ☐ Text

PERSON TO CONTACT IN CASE OF EMERGENCY: _____

RELATIONSHIP: _____ DAYTIME PHONE: (___) _____

HOW DID YOU HEAR ABOUT US? (Please check all that apply)

☐ Doctor ☐ Family Member ☐ Friend ☐ Google ☐ Facebook ☐ YouTube ☐ PhysicalTherapists.com ☐ Healthgrades

REFERRING PHYSICIAN: _____ PHONE: (____) _____

FAMILY PHYSICIAN: _____ PHONE: (____) _____

PATIENT'S EMPLOYER: _____ PHONE: (____) _____

EMPLOYER ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

POSITION : _____ YEARS ON JOB: _____

NAME OF INSURANCE PROVIDER: _____

IS INSURANCE UNDER ANOTHER PERSON'S NAME? (Spouse, Parent, Other): ☐ Yes ☐ No

If yes, NAME OF INSURED: _____

INSURED DATE OF BIRTH: _____ RELATIONSHIP: _____

INSURED'S EMPLOYER: _____ WORK PHONE: (____) _____

EMPLOYER ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

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Due to constantly changing insurance regulations, benefits, and deductibles, we are only able to approximate your insurance benefits. If your insurance pays more than expected, you will be credited the difference. If your insurance company pays less than expected, you will be charged for the difference. Final responsibility for payment rests with the person responsible for your account.

Upon admission to our facility, it is very important that you, the patient, inform us, the provider, regarding the circumstances surrounding your injury. In certain instances, an insurance company may recoup its' payment for information withheld from the providers or the patients.

If applicable, have you given the office staff any litigation details and/or attorney information, necessary to process your claim?

_____ YES _____ NO If no, please explain: _____

_____

Attorney Name/Address/Phone: _____

Court/Case Number: _____

The insurance benefit information listed on page one is the expected eligible coverage for your insurance contract and we will process your insurance claim. You must realize that your insurance coverage is a contract between you and your insurance company. Not all services are a covered benefit in all contracts. We are legally required to charge for deductibles and copays that apply to your contract. These charges are your responsibility. If necessary, please contact us promptly for assistance in the management of your account.

- I hereby authorize direct payment of benefits otherwise payable to me, to David Gilboe and Associates, P.C. I understand that I am financially responsible to David Gilboe and Associates, P.C. and my Physical Therapist for charges not covered by this agreement.
- I understand that I am obligated to pay all co-payments at the time agreed upon by David Gilboe and Associates, P.C. and myself.
- I authorize any holder of medical or other information about me to release such information as necessary to process these claims or related medical claims.
- I permit a copy of this authorization to be used in place of the original.

As part of our therapeutic relationship, we strive to use progressive communication tools such as email and SMS texting to keep you informed and connected with us. Our services include sending you a monthly email newsletter and spontaneous tips for your wellness. *We do not send personal information in our communications.*

Most messages are sent through email and occasionally through SMS texting. For email communications, you may choose to unsubscribe at any time to our newsletters and tips, and a link to unsubscribe is provided with every communication. For SMS texting, click the link to our communication and the option to unsubscribe is visible at the bottom of your screen. We understand that some phone carriers have text messaging fees and we are not responsible for these costs. *Your email address and phone number are never shared with anyone and we keep your information strictly private.*

Pursuant to Title VI, Section 504 of the Rehabilitation Act of 1973, it is the policy of David Gilboe and Associates, P.C., to employ, admit and treat all persons without regard to race, color, national origin, handicap, contagious disease or age.

By signing this form, you acknowledge that you have been informed of our privacy practices and procedures for the use and disclosure of your protected health information.

I have received and read this agreement and declare that the information is true to the best of my knowledge and belief. I understand and agree to all of the terms.

_____

Patient Signature (if minor, parent or guardian) Date

_____

Witness Signature (David Gilboe and Associates, P.C.) Date

PATIENT HISTORY FORM

Instructions: Please fill out as complete as possible. All information will be kept confidential.

PATIENT NAME:_____ Height_____ Weight_____

A. CURRENT MEDICATIONS (name only):_____

_____

_____

☐ See attached list

B. HEALTH HISTORY:

1. ILLNESS / MEDICAL PROBLEM:

Please put an X by any of the following conditions you have/had and give an approximate year that they started. Use the lines below for any additional comments or explanations.

ILLNESS	X	YEAR	EXPLANATION
High Blood Pressure	☐		
Heart Attack	☐		
Chest pain	☐		
Congestive Hrt Failure	☐		
Blood Clot	☐		
Irregular hrt beat	☐		
Mitral valve prolapse	☐		
Other heart conditions	☐		
Emphysema	☐		
Asthma	☐		
Shortness of breath	☐		
HIV	☐		
Cancer or tumor	☐		
Stomach/GI condition	☐		
Liver trouble	☐		
Hepatitis	☐		
Hernia	☐		
Kidney or bladder disease	☐		
Prostate problem	☐		
Headaches	☐		
Dizziness	☐		
Seizures	☐		
Thyroid disease	☐		
Head injury	☐		
Stroke	☐		
Arthritis	☐		
Bleeding tendency	☐		
Diabetes	☐		
Skin conditions	☐		
Mental illness/depression	☐		
Broken bones	☐		
Joint sprains	☐		
Eye/vision problems	☐		
Hearing loss	☐		
Allergies	☐		
Other	☐		

2. SURGERIES: □ Gall Bladder □ Tonsils □ Appendix □ Hysterectomy
□ Hernia □ C-Section □ Coronary Bypass □ Thyroidectomy
□ Neck surgery □ Back surgery □ Carpal tunnel □ Cataract
□ Other (please list)_____
_____
Do you have anything artificial in your body? List:_____
_____

3. SPECIAL TESTS: relating to current condition

C. SOCIAL / PERSONAL HISTORY:

Currently live: □ Alone □ With parents □ With siblings □ With spouse □ With children Ages?_____
□ With friends □ With significant other

Type of dwelling: House □ one-story □ two-story □ three-story
Apartment □ 1st floor □ 2nd floor □ other_____
Other_____

Laundry: □ basement □ 1st floor □ 2nd floor □ Laundry mat

How many stairs does it take to enter your home?_____

Have you experienced any falls within the past six months? □ Yes □ No
If yes, describe circumstance:_____
_____

Do you have relatives / friends who can help you with your care? □ No □ Yes Who?_____
Do you have relatives / friends who are dependent on you for care? □ No □ Yes Who?_____
Do you exercise regularly? □ No □ Yes How often?_____
Type of exercise:_____
Are you involved in sports? □ No □ Yes What type?_____
Has the problem you have come to physical therapy for limit your participation in exercise or sports?
□ No □ Yes
Do you have any hobbies? □ No □ Yes Describe:_____

Do you smoke? □ No □ Yes How much?_____

Do you currently work outside of the home? □ No □ Yes
If yes, describe the activities you have to perform to complete your job:_____
_____
_____

Signature of person filling out form:_____ Date_____

OFFICE USE ONLY (Below)

I have reviewed the Patient History Form as provided.

Therapist Signature:_____ Date_____