Britt Zink Physical Therapy Services LLC

Britt Zink, MSPT, Cert MDT, ITPT

Welcome to our practice!

Please help us serve you better by taking a few minutes to provide the following information

Prior/Established Patient (patient has been seen at this clinic in the past: designate accordingly below):

☐ **Same as previous episode of care** (no changes from last episode of care at clinic)

☐ **Same as previous episode of care** (except changes as noted on this document)

New Patient Information: to be completed by patient

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

Date of Birth: _____SSN_____ Gender: ☐ Male ☐ Female Address:

_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile: _____Work: _____

Email: _____

Language_____Interpreter needed: ☐ yes ☐ no

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Active Military ☐ None

☐ Self Employed Student Status: ☐Full time ☐ Part Time ☐ NA

Employer: _____Occupation: _____

Employer's Address: _____

City:_____State: _____Zip: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouses Name: _____DOB: _____Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Physician: _____

Hobbies/Recreational Activities: _____

Is this illness/problem the result of: ☐ Accident at Work ☐ Auto Accident ☐ Other type of accident/injury

☐ Non-Accident ☐ Other

If being seen for accident or MVA: Contact person/Attorney or Case Manager Name:_____

Phone: _____ Claim #: _____

Are you currently receiving or have your received Home Health Services (including any therapy, nursing, Bathing, dressing, etc) in the past 60 days? ☐ Yes ☐ No

Are you currently receiving or have you received other therapy services in the past 60 days? ☐ Yes ☐ No

Have you received other treatment for this condition? (e.g physical therapy, massage chiropractor?

_____

Who can we thank for referring you to our practice? How did you hear about us? _____

Primary Insurance Information: ☐ See scanned insurance card(s)

Primary Insurance Company Name: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Number/ID:_____ Group #: _____

Relationship to Policyholder: _____

Secondary Insurance Information:

Insurance Company Name: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Number/ID:_____ Group #: _____

Relationship to Policyholder: _____

If under the age of 19, please be sure to include parent(s) or legal guardians (person responsible for bill).

Mother/Legal guardian: _____ Date of Birth: _____ SSN: _____

Address (if different from patient): _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile: _____ Work: _____

Mother Email: _____

Mother Employer: _____ Occupation: _____

Father/Legal guardian: _____ Date of Birth: _____ SSN: _____

Address (if different from patient): _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile: _____ Work: _____

Father Email: _____

Father Employer: _____ Occupation: _____

Past Surgical History: Please list any Past Surgeries

_____ Year: _____

_____ Year: _____

_____ Year: _____

_____ Year: _____

_____ Year: _____

_____ Year: _____

_____ Year: _____

Past Medical History: Please check any past or present medical problems that pertain to *YOU:*

☐ Acid reflux (GERD) ☐ Anemia ☐ Anxiety ☐ Asthma ☐ Arthritis ☐ Auto-Immune Disease (Specify)_____

☐ Bleeding disorder ☐ Blood Clots/DVT/PE ☐ Bowel Disorder

☐ Cancer: Type: _____ ☐ Chemotherapy ☐ Radiation

☐ COPD ☐ Congestive Heart Failure (CHF) ☐ Coronary Artery Disease (CAD) ☐ Crohn's Disease

☐ Defibrillator/Pacemaker ☐ Depression ☐ Diabetes ☐ Emotional Difficulty ☐ Emphysema

☐ Epilepsy/Seizures ☐ Fibromyalgia ☐ Falls ☐ Fracture ☐ Gastrointestinal Disease ☐ Gout

☐ Headaches/Migraines ☐ Hepatitis ☐Hearing Loss ☐ Heart Arrhythmia ☐ Heart Attack (MI)

☐ Heart Problems ☐ Heart Surgery ☐ Hernia ☐Hyperlipidemia/ High cholesterol

☐ History of COVID-19 Infection ☐ HIV/AIDs ☐ Hypertension/High Blood Pressure

☐ Hypotension/Low Blood Pressure ☐ Incontinence (urinary) ☐ Incontinence (bowel)

☐ Kidney Disease ☐ Liver Disease ☐ Lung Disease ☐ Lupus ☐ Lymphedema ☐ Lymphoma

☐ Multiple Sclerosis (MS) ☐ Neurologic Disorder ☐ Neuropathy ☐ Organ Transplant ☐ Osteoporosis

☐ Osteopenia ☐ Osteomyelitis ☐ Parkinson's Disease ☐ Peripheral Vascular Disease ☐ Polio

☐ Rheumatoid Arthritis ☐ Sleep Apnea ☐ Stroke ☐ Tinnitus/Ringing in ears

☐ Thyroid Disease: Low Thyroid/Hypothyroidism ☐ Thyroid Disease: High Thyroid/Hyperthyroidism

☐ Tuberculosis (TB) ☐ Ulcers ☐ Vertigo/Dizziness

☐ Other: Please specify: _____

Do you smoke: ☐ Yes ☐ No If "yes," how many packs per day? _____

Do you drink alcoholic beverages? ☐ Yes ☐No

Allergies: _____ **Latex Allergy?** ☐ Yes ☐ No

Allergic to Dexamethasone? ☐ Yes ☐ No

Current Medications: please list your current medications

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Have you fallen in the past year? ☐ Yes ☐ No

Is there a chance you could be pregnant at this time? ☐ Yes ☐ No

What is the primary issue/problem that brings you in today? _____

What do you feel brought on this illness/problem? _____

As a result of this issue, what are you having difficulty with? _____

When did your symptoms begin? _____

Please rate your pain in the past 48-72 hours: (using the scale "0 - 10" where 0 is no pain and 10 is the worst Pain possible) At its Best: _____ At its Worst: _____ At Present: _____

What time of day is your pain at its best? _____ At its worst? _____

What activities or positions make you feel better? _____

What activities or positions make your pain worse? _____

What are your goals for treatment? _____

This serves as acknowledgement that you have received a copy of the Britt Zink Physical Therapy Services LLC's Notice of Privacy Practices and the Attendance and Payment Policy, and that you consent to treatment. Please fill out the lines below.

ACKNOWLEDGMENT

☐ I have read the Notice of Privacy Practices and I have had the opportunity to ask questions and have them answered to my satisfaction. If I am not the patient identified on this form, I represent that I am authorized by law to agree to these conditions on the patient's behalf and am authorized representative of the patient. A copy of this form is as effective and valid as the original. Privacy notice is found here: https://brittzinkpt.com/wp-content/uploads/2026/01/Britt-Zink-Physical-Therapy-Services-Notice-of-Privacy-Practices-1-1.pdf

☐I have read and understand the patient financial policy and cancellation/no show policy and agree to its terms and conditions. Attendance and Financial Policy is found here: https://brittzinkpt.com/wp-content/uploads/2026/01/Attendance-and-Financial-Policy.pdf

Printed Name: Date of Birth: _____

X_____Relationship to patient: ☐ self ☐ parent ☐

Guardian Signature of Client, Guardian or Responsible Party

X

Private Practitioner/Witness

Private Practitioner / Witness Date