

Southwest Medical Group Physical Examination Form

Below to be completed by Patient (Please Print)

Patient Name _____ Telephone () _____
Patient Address _____ City _____ State _____ Zip _____
Date of Birth _____ Drivers License Number _____
Patient's primary medical complaint: _____

Below to be completed by Physician or Medical Examiner (Please Print)
Please forward the results of this examination to Southwest Medical Group by fax 1-877-552-6665

Examiner name: _____ Phone: _____
Organization/facility: _____ Fax: _____
Provider address: _____ City: _____
State: _____ Zip Code: _____ Patient ID Verified? Yes No

Examiner's Findings:

BP: _____ Pulse: _____

Height: _____ Weight: _____ BMI: _____ (for office use only)

Please circle either Yes, No, or Not Applicable (N/A):

Are you Ambulatory	Yes	No	N/A
Do you have any Surgical scar(s)	Yes	No	N/A
Do you have Suicidal Ideation	Yes	No	N/A
Do you have a Migraine Headache complaint	Yes	No	N/A
Do you have an Anxiety/Panic disorder complaint	Yes	No	N/A
Do you have an Insomnia complaint	Yes	No	N/A
Have you been referred to a specialist	Yes	No	N/A

List Current Medications/Supplements Patient is currently taking:

Has the Patient ever been allergic to any type of Medications or Foods? Yes No

If yes, please explain: _____

Patient Medical History

Examiner's signature: _____ Date: _____

I acknowledge that the information provided above is both accurate and truthful to the best of my knowledge.

I hereby release EMSI, Inc. and Southwest Medical Group, LLC. of any liability associated with the medical claims or treatment based on the medical claims that I have made above.

I certify I am requesting the release of this information to Southwest Medical Group, LLC by EMSI, Inc. from whom I am receiving supplementary care and treatment.

Patient Signature: _____ Date: _____

For office use only

Received: Y N (circle)	PT Approved Y N (circle)	PT ID: _____
Date Received: _____	PT Counselor _____	Initials: _____