Patient Name_____ DOB_____ ❑ Male ❑ Female

Address_____ City_____State_____ Zip_____

Mailing Address (if different)_____ City_____State____Zip_____

Home/ Cell Phone_____ Email_____ SSN_____

Employer Name_____ Work Phone_____

Spouse Name_____Spouse DOB_____Spouse Phone_____

Emergency Contact_____ Telephone_____How did you hear about us?_____

Primary Care Physician_____ Clinic_____

Referring Provider if different from above_____ Clinic_____

Have you had PT this year at any other locations? ❑ Yes ❑ No If yes, where?_____ How many visits?_____

COMPLETE THIS SECTION IF THE PATIENT IS UNDER THE AGE OF 18 OR IS A COVERED DEPENDENT

Mother's Information

Name_____DOB _____ Phone_____

Address _____SSN _____

Employer_____Work Phone_____

Father's Information

Name_____DOB _____ Phone_____

Address _____SSN _____

Employer_____Work Phone_____

INSURANCE INFORMATION

Primary: Policyholder Name_____ DOB _____Relation_____

Insurance Company_____ID/Claim #_____ Group #_____

Secondary: Policyholder Name_____ DOB _____Relation_____

Insurance Company_____ID/Claim #_____ Group #_____

Workers Compensation: Injury Date_____ Claim ID #_____

Worker's Comp Insurance Co._____ Employer_____

Is Today's visit the result of an Auto/Motorcycle injury? ❑ Yes ❑ No Insurance Company_____

Injury Date_____ Claim ID #_____

Attorney Name(if applicable)_____Phone_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY

I, _____, acknowledge that Pro Physio office has a posted Notice of Privacy Practice available in the patient reception area. A copy is available by request. I authorize the release of all my medical records, including correspondence, reports, MRI, & itemized bills to another doctor, hospital, clinic, my insurance company, and lawyer, at my request, at any time.

_____ _____

Signature **Date**

INFORMED CONSENT AND PAYMENT POLICY

1. **I consent to examination, treatment, & procedures that may be performed at Pro Physio considered necessary by the Physical Therapist.**
2. **I authorize the release of any medical information necessary to determine benefits payable for insurance claims for service rendered.**
3. **I understand that Pro Physio will bill my insurance as a courtesy, but I am financially responsible for all charges whether/not paid by my insurance.**
4. **I agree to pay monthly payments if insurance claims are pending past 60 days.**
5. **I agree to pay all collection and lawyer fees up to and including 40% of the balance fee as may be charged by a collection agency if my account becomes delinquent & a collection agency is required; this will be added to the balance on my account.**
6. **I agree to pay copayments or coinsurance at the time of service or on a weekly basis if Pro Physio bills my insurance.**
7. **I agree to pay $25 no show/ cancellation fee, *at the office discretion*, if notice is not given or is less than 24 hours.**
8. **I consent to have my photograph taken for ❑ Therapy Purposes ❑ Marketing Purposes**

_____ _____ _____

Signature **SSN** **Date**

MEDICAL SCREENING

Name_____ DOB_____ Date_____

Gender ❑ Male ❑ Female Smoker ❑ Yes ❑ No Pregnant ❑ Yes ❑ No

Occupation_____ Describe your regular exercise_____

Have you had imaging? ❑ Xray ❑ CT ❑ MRI ❑ Other Date and Facility_____

Please list all current medications_____

_____

Do you take blood thinners? ❑ Yes ❑ No Name of Blood Thinner_____

Past Surgical History (check any applicable and date) ❑ None ❑ Pacemaker _____ ❑ Joint_____

❑ Spinal_____ ❑ Other _____

Past Medical History Please check any condition that you have been told you have (or had).

❑ Stroke	❑ Anxiety	❑ Heart Disease	❑ Latex Allergy
❑ Bipolar	❑ Depression	❑ Liver Disease	❑ Diabetes I or II
❑ PTSD	❑ Osteoporosis	❑ Lung Disease	❑ Sexually Transmitted Disease
❑ Fibromyalgia	❑ Osteoarthritis	❑ Kidney Disease	❑ Chronic wounds
❑ Ulcers	❑ Asthma/ Emphysema	❑ High Blood Pressure	❑ Hepatitis A B C
❑ Headaches	❑ HIV/AIDS	❑ Low Blood Pressure	❑ Ulcers
❑ Migraines	❑ Seizures/ Epilepsy	❑ Rheumatoid Arthritis	❑ Blood Clotting Disorder
❑ Cancer	❑ History of Fractures	❑ Metal Plates/Screws	❑ Gout

❑ Other_____

Currently I am experiencing (check all that apply) ❑ Fever/Chills/Sweats ❑ Poor balance (or falls)

❑ Dizziness	❑ Numbness or Tingling	❑ Difficulty swallowing	❑ Increased pain at night
❑ Headaches	❑ Nausea/Vomiting	❑ Shortness of breath	❑ Changes in appetite
❑ Depression	❑ Unexplained Weight Loss	❑ Changes in bowel/ bladder function	

Current Symptoms

Where are you currently having symptoms?_____

What date did your present pain start?_____ How? ❑ Gradually ❑ Suddenly ❑ Injury _____

My symptoms are currently ❑ Getting better ❑ About the same ❑ Getting worse

Have you received any treatment for this problem?_____

Have you had this problem before? ❑ Yes ❑ No If yes, how was the problem treated? _____

How long did it take for you to feel better?_____

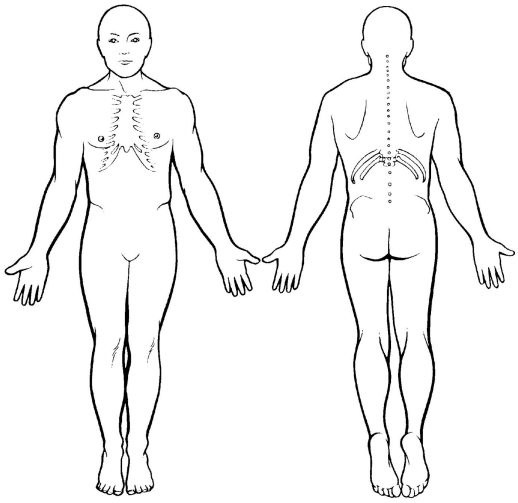
How are you able to sleep at night? ❑ Fine ❑ Moderate difficulty ❑ Only with medication

What are your personal goals for therapy?_____

Do you have any barriers to learning? If so, list _____

Please circle the number below which best represents your overall average level of function.

Cannot do Anything	0	1	2	3	4	5	6	7	8	9	10	**Able to do Everything**



Please use the chart to the right to circle the areas where you feel pain.

For the therapist
+/- Cough/Sneeze
+/- Saddle Anesth.
+/- Bwl/Blddr Change
+/- Numb/Ting

On the scales below, please circle the number which best represents the severity of your pain.

Average for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Best for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Worst for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

What makes your symptoms better?_____

Please check the activities which make your pain worse:

❑ **Lying down** ❑ **Standing** ❑ **Walking** ❑ **Stress**

Any other activities that make your pain worse?_____

Please list the time of day for your symptoms when you feel your best _____

Please list the time of day for your symptoms when you feel worse_____

Aggravating Factors Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem.

1._____

2._____

3. _____

CONSENT: I understand that my diagnosis & treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered. _____ _____

Signature Date