Patient Information & Medical History Form

Name: _________________________________ Today's Date: ___________________

Phone #: _______________________ Email: ____

Occupation: ________________________________ Date of Birth: ________________________

Height: ____________ Weight: _____________ Social Security number: ________________________

Emergency Contact: ______________________ Relationship: _____________ Phone Number: _____________

Referring Physician or Primary Family Physician: ____

Current Complaint: ____

Injury Type: ____

Date of Onset of Symptoms: _________________________________

- Do you have a history of falling? ☐ Yes ☐ No

  If yes: Do you take medication that contributes to your falls? ☐ Yes ☐ No

- Do you have a history of your blood pressure dropping when moving from lying down to sitting up? ☐ Yes ☐ No

- Do you have visual problems that may contribute to your falls? ☐ Yes ☐ No

Have you had an MRI or x-rays that are relevant to your condition? ☐ Yes ☐ No

- **If yes**, when & where was testing done?____
- Test Results indicated?: ____

Have you had any of the following for the condition we are seeing you for?

☐ Chiropractic Care ☐ Massage Therapy ☐ Physical Therapy ☐ Home Healthcare

☐ Other: _________________________

Have you had any **surgery** that is relevant to the issue that brings you here today?

- Surgery Type: _____________________________________
- Surgery Date: _____________________________________
- Surgical Restrictions and Precautions: ____

PERFORMANCE
Physical Therapy & Wellness

Patient Information & Medical History Form - page 2

Where is your pain? ____

What is your pain level? 0 = no pain, 10 = severe pain

Currently: 0 1 2 3 4 5 6 7 8 9 10

At best: 0 1 2 3 4 5 6 7 8 9 10

At worst: 0 1 2 3 4 5 6 7 8 9 10

What makes your pain worse? ____

What makes your pain better? ____

What is difficult for you to do? ____

Functional Limitations (Check all that Apply)

☐ Walking	☐ Stairs	☐ Transferring from chair or bed
☐ Running	☐ Exercise	☐ Reaching
☐ Standing	☐ Lifting	☐ Bathing
☐ Sitting	☐ Working	☐ Balance
☐ Squatting	☐ Dressing	

What job duties or activities do you perform? ____

____

What are your goals for therapy? ____

____

Patient Information & Medical History Form - page 3

Medical History (Check all that apply)

- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Cauda Equina Syndrome
- ☐ Cerebral Vascular Accident
- ☐ Current Infection
- ☐ Diabetes - Type 1
- ☐ Diabetes - Type 2
- ☐ Fibromyalgia
- ☐ Current/suspected Fracture ______________________
- ☐ High Blood Pressure
- ☐ Huntington's Disease
- ☐ Immunosuppression
- ☐ Lupus
- ☐ Muscular Dystrophy
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Rheumatoid Arthritis
- ☐ Traumatic Brain Injury

Please list all previous surgeries and/or medical procedures:

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Please list all <u>current</u> medications with dosage and method (oral, topical, etc.)

Prescription: ____

Over-the-counter: ____

Herbals/Vitamins/Mineral Supplements: ____________________________________

By signing below, I acknowledge that the information provided above is correct.

Patient (Guardian) Signature: _____________________________________ Date______________________

Patient Authorization, Release of Information & Consent for Treatment

Patient Name: ______________________________________

I am aware of my diagnosis and wish to receive treatment at Performance Physical Therapy & Wellness, LLC, hereafter, referred to as PPTW. I permit its employees and other persons caring for me to treat in ways they judge are beneficial to me. I consent to rehabilitation and related services at this Facility. I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. I understand that this care can include an evaluation, testing, and treatment. No guarantees have been made to me about the outcome of this care. I give permission to PPTW to release information, verbal and written, contained in my medical record and other related information to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assigned and/or beneficiaries, and all other related persons as it relates to my treatment and/or payments for services provided. I authorize PPTW to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

Initials ___________

Assignment of Benefits

I authorize payment directly to PPTW for any Physical Therapy service provided. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Initials ___________

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

I acknowledge that I have been given a copy of the Notice of Privacy Practices for PPTW or that I can request a copy at any time, if desired. In addition, I hereby consent to the use and disclosure of my personal health and information for the purposes of treatment, payment, and healthcare procedures.

Initials ___________

Payment Guarantee

I agree to pay PPTW for the services provided to me or the party named above. If any law such as Workers' Compensation or Insurance contract prohibits payment for these services, I will cooperate and assist in the provision of information, authorization, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances. If the information provided by the insurance company is not accurate or the insurance coverage changes, I will be responsible for payment for services. I understand that my "good-faith" payment may not be inclusive of all payments for which I am responsible and I may be billed for any remaining balance. I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments. If my account is not resolved in a timely manner and it is turned over to collections, I understand that I will be responsible for the original balance of my account, as well as up to 30% in collection fees.

Initials ___________

Patient (or Guardian) Signature: ____

Date: _____________________________

Policies

Coverage

As a courtesy, we check your benefits. However, **this does not guarantee payment**. You are encouraged to check your policy to verify coverage.

Good Faith Payment Plan

We have contractual agreements with some insurance companies to collect co-pays at each visit. Therefore, we request patients who have a co-insurance payment obligation, to pay a percentage of the payment at each time of service.

Cancellations

In the event you are unable to keep your appointment, we ask that you notify us at least 24 hours prior, if possible. We reserve the right to charge $35 for any missed appointment.

How did you hear about us?

- ☐ Friend/Family
- ☐ Physician
- ☐ Newspaper
- ☐ Radio
- ☐ Facebook, Social Media, etc.
- ☐ Web Search
- ☐ Returning Patient
- ☐ Other ______________________

By signing below, I acknowledge that I understand the above information.

Patient (or Guardian) Signature: ____

Date: _______________________