



PATIENT INFORMATION

PATIENT (LEGAL) NAME: _____ SEX: _____ BIRTHDATE: _____

PREVIOUS/MAIDEN NAME(s): _____ SSN: _____ PHONE: _____

PHYSICAL ADDRESS: _____

MAILING ADDRESS: _____ City _____ State _____ Zip _____ CELL: _____

EMPLOYER: _____ PHONE: _____

SPOUSE NAME: _____ SPOUSE DOB: _____ PHONE: _____

SPOUSE EMPLOYER: _____ SPOUSE WORK PHONE: _____

EMERGENCY CONTACT (OUTSIDE OF HOME): _____ PHONE: _____

EMAIL (FOR APPT REMINDERS): _____

HOW DID YOU HEAR ABOUT US?

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

(Please note: If you are over 18, but covered by your parent(s) insurance plan, we can bill your parent(s) for you as a courtesy. Please understand you are ultimately responsible for any unpaid balances on your account.)

MOTHER'S INFORMATION:

NAME: _____ DOB: _____ PHONE: _____

ADDRESS: _____ EMPLOYER: _____ WORK PHONE: _____

FATHER'S INFORMATION:

NAME: _____ DOB: _____ PHONE: _____

ADDRESS: _____ 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 #: _____

PLEASE READ -- IMPORTANT INFORMATION

1. I consent to examination, treatment and procedures that may be performed during office visits considered necessary by the physical therapist.
2. I authorize the release of any medical information necessary to determine benefits payable for insurance claims for services rendered and agree that all proceeds of insurance are assigned to this office where applicable.
3. I understand that I am financially responsible for all charges whether or not paid by my insurance.
4. I understand that should I default on payment of my account and collection agency services are required, all costs of collections, up to 45% of the balance, including attorney/court costs, will be added to the balance of my account.
5. I agree to make monthly payments on unpaid balances exceeding sixty (60) days even when insurance claims are pending. These payments will be established in accordance with APRS policy.
6. A one percent (1%) finance charge may be assessed against the unpaid balance of any and all accounts that I am responsible for in accordance with APRS policy.
7. If APRS bills my insurance company directly I will pay my co-payment of 20% per visit or the co-payment amount that coincides with my insurance policy. The co-payment is payable on a per visit or weekly basis.
8. Per HIPAA regulations, I acknowledge that this office has a posted Notice of Privacy Practice available in the patient reception area. A copy is available by request. We will not use or disclose your health information without your authorization, except as described in this notice.

SIGNATURE OF RESPONSIBLE PARTY (PATIENT OR PARENT/GUARANTOR IF PATIENT IS A MINOR)

DATE

MEDICAL INFORMATION

NAME: _____

DATE: _____

A. PLEASE READ AND ANSWER THE FOLLOWING QUESTIONS:

1. ARE YOU CURRENTLY ENGAGING IN ANY FORM OF EXERCISE? _____

IF YES, LIST ACTIVITY, FREQUENCY AND INTENSITY: _____

2. HOW ACTIVE IS YOUR LIFESTYLE? ___ SEDENTARY ___ MODERATE PHYSICAL ACTIVITY ___ HEAVY PHYSICAL ACTIVITY

3. WHAT IS YOUR JOB TITLE IF CURRENTLY WORKING? _____
 DESCRIBE THE TYPES OF ACTIVITIES INVOLVED IN YOUR JOB (HEAVY LIFTING, STAIR CLIMBING, WALKING, SITTING AT DESK, ETC):

4. PLEASE INDICATE YOUR EXPECTATIONS AND GOALS FOR YOUR TREATMENT: _____

B. PLEASE FILL OUT YOUR PAIN LEVELS AND MARK WHERE YOU ARE FEELING THE PAIN ON THE DIAGRAM BELOW.

PAIN / DISCOMFORT/DIZZINESS DESCRIPTION

SYMPTON FREQUENCY:

- ___ CONSTANT
- ___ COMES AND GOES AT REGULAR TIMES
- ___ HAPPENS ONCE IN A WHILE

RELATIONSHIP OF SYMPTOMS TO SLEEP:

- ___ WAKES FROM SLEEP
- ___ PREVENTS SLEEP
- ___ BETTER AFTER SLEEP

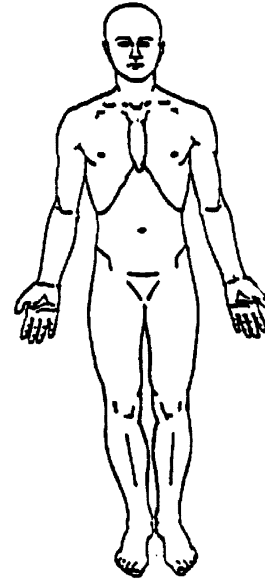
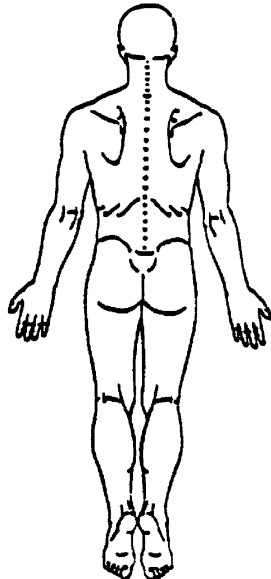
SYMPTOM SCALE-

0 BEING NONE AT ALL

10 BEING AS BAD AS IT CAN BE

AT WORST	0	1	2	3	4	5	6	7	8	9	10
CURRENT	0	1	2	3	4	5	6	7	8	9	10
AT BEST	0	1	2	3	4	5	6	7	8	9	10

Key: /// Stabbing XXX Burning 000 Pins & Needles === Numbness



PATIENT SIGNATURE: _____ DATE: _____

MEDICATION INFORMATION

NAME: _____

DATE: _____

MEDICAL HISTORY:

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

- | | | |
|---|--|---|
| <input type="checkbox"/> ALZHEIMER'S | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> OSTEOARTHRITIS |
| <input type="checkbox"/> CARDIOVASCULAR DISEASE | <input type="checkbox"/> HISTORY OF CANCER | <input type="checkbox"/> PARKINSON'S |
| <input type="checkbox"/> CURRENT INFECTION | <input type="checkbox"/> HUNTINGTON'S | <input type="checkbox"/> PREGNANT/POSSIBLY PREGNANT |
| <input type="checkbox"/> CVA/STROKE | <input type="checkbox"/> LUPUS | <input type="checkbox"/> RHEUMATOID ARTHRITIS |
| <input type="checkbox"/> DIABETES TYPE 1/TYPE 2 (CIRCLE) | <input type="checkbox"/> MUSCULAR DYSTROPHY | <input type="checkbox"/> TRAUMATIC BRAIN INJURY |
| <input type="checkbox"/> FIBROMYALGIA | <input type="checkbox"/> HIV, HEPATITIS B, HEPATITIS C | |
| <input type="checkbox"/> PREVIOUS FRACTURED BONES (IF SO WHICH ONES): _____ | | |

OTHER: _____

PLEASE LIST BELOW YOUR CURRENT PRESCRIPTION(S), OVER-THE-COUNTER, HERBAL, VITAMIN/ MINERALS / DIETARY (NUTRITIONAL SUPPLEMENTS) MEDICATIONS. IF YOU HAVE A CURRENT LIST OF YOUR MEDICATIONS WITH ALL OF THE BELOW INFORMATION, PLEASE PROVIDE IT TO THE FRONT OFFICE AND THEY CAN MAKE A COPY.

PRESCRIPTION MEDICATIONS:

MEDICATIONS	DOSAGE	FREQUENCY	ROUTE (EX:ORALLY)	REASON FOR TAKING

OVER-THE-COUNTER / HERBAL/ VITAMIN /MINERAL / DIETARY (NUTRITIONAL SUPPLEMENT):

MEDICATIONS	DOSAGE	FREQUENCY	ROUTE (EX:ORALLY)	REASON FOR TAKING

For Future Appointments Only

I _____, AFFIRM THAT THE ABOVE MEDICATION LIST AND MEDICAL HISTORY IS ACCURATE AND ANY NECESSARY CHANGES HAVE BEEN MADE.

SIGNATURE: _____ DATE: _____

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SIGNATURE: _____ DATE: _____

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SIGNATURE: _____ DATE: _____