Date:

1. Patient Info

_____ _____ Male Female _____
FULL NAME PREFERRED NAME (circle one) DATE OF BIRTH

_____ _____ _____ _____
STREET ADDRESS CITY STATE ZIP CODE

(_____)_____ Is this a CELL or HOUSE phone? _____
PHONE (circle one) EMAIL ADDRESS

WORK STATUS: ___CURRENTLY EMPLOYED ___RETIRED ___DISABLED Occupation:_____

_____ _____ (_____)_____
EMERGENCY CONTACT PERSON RELATIONSHIP PHONE

_____ _____
PRIMARY PHYSICIAN REFERRING PHYSICIAN (if different)

_____ _____
PRIMARY INSURANCE SECONDARY INSURANCE (if applicable)

2. Referral Info

HOW DID YOU HEAR ABOUT US?

___I HAVE BEEN HERE BEFORE ___INTERNET
___FRIEND/FAMILY ___INSURANCE/DIRECTORY
___ADVERTISEMENT ___BROCHURE
___PHYSICIAN OFFICE ___DRIVE BY
___OTHER: _____

WHO CAN WE THANK FOR REFERRING YOU HERE?

_____

3. Appointment Reminders

WOULD YOU LIKE APPOINTMENT REMINDERS?

_____YES _____NO

IF YES, WHICH METHOD DO YOU PREFER?

___TEXT MESSAGE
___EMAIL
___PHONE CALL

4. Payment Info

I AM HERE FOR:

_____ Physical Therapy _____ Silver Fox Wellness Club

AND I AM PAYING TODAY BY:

_____ **INSURANCE** (PHYSICAL THERAPY ONLY) AND WOULD LIKE TO HAVE YOU DEAL DIRECTLY WITH MY INSURANCE COMPANY(IES). I WILL ASSIGN MY BENEFITS TO YOU BY SIGNING THE "ASSIGNMENT OF BENEFITS".

_____ **CASH, CHECK OR CREDIT CARD** I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT AT TIME OF SERVICES AND ACKNOWLEDGE YOUR "FINANCIAL POLICY".

MEDICAL HISTORY

1. Please list your past medical and/or surgical history. _____
_____
2. Do you feel like you are abused physically or emotionally? _____ Yes _____ No
3. Have you had any falls in the past year? _____ Yes _____ No If yes, how many? _____
If yes, were you injured in the fall(s)? _____ Yes _____ No Do you have a fear of falling? _____ Yes _____ No
4. Please list any medications (prescription, herbal, or over-the-counter), including the names, dosages, frequency, and route of administration, or provide us with a copy of your medication list: _____
_____
5. Are you a tobacco user? _____ Yes _____ No How many hours of sleep do you get a night? _____
6. Do you have any unexplained weight loss? _____ Yes _____ No
7. Do you have any urinary leakage or incontinence? _____ Yes _____ No
8. How many minutes of moderate intensity exercise do you get per week? _____
9. How would you describe your general health? _____ Excellent _____ Good _____ Fair _____ Poor
10. Over the last 2 weeks, how often have you been bothered by the following problems? (PHQ-2)
-Little interest or pleasure in doing things: □Not at all □Several days □More than half the days □Nearly every day
-Feeling down, depressed, or hopeless: □Not at all □Several days □More than half the days □Nearly every day

PHYSICAL THERAPY QUESTIONNAIRE

1. Please describe the problem that brings you in to see us. How and when did this problem start? _____
_____
2. Have you had any diagnostic tests for this problem (X-ray, CT scan, MRI, etc.)? _____
3. Did you have surgery for this problem? _____ Yes _____ No If yes, what kind?_____
4. Have you received other treatment for this problem? For example, physical therapy or chiropractic care?
_____ Yes _____ No If yes, please explain: _____
5. If you are experiencing pain, where is your pain located? _____
On a scale of 0-10, how would you rate your pain? (0= no pain, 10= excruciating pain)
Currently: _____ In the past 24 hours, At best: _____ At worst: _____
Please check any of the following that describes your pain:

_____ Burning	_____ Aching	_____ Sharp	_____ Shooting
_____ Throbbing	_____ Dull	_____ Nagging	_____ Numbness/tingling
_____ Constant	_____ Intermittent	_____ Occasional	_____ Brief

Is your pain worse in the morning, afternoon, evening, or during the night? (please circle if yes)
Have you noticed anything that makes your pain better or worse? _____
_____
6. List 1 or 2 things that you are having trouble doing, that you would like to do better (your goals for therapy):
1. _____
2. _____

The information I listed above is the best to my knowledge.

_____ _____ _____
Name (printed) Signature Date

OFFICE USE ONLY Height (in)_____ Weight (lbs)_____ BP _____ O2 sats_____ Pulse rate (bpm)_____

Physical Therapy Patient Information Consent Form

INFORMED CONSENT TO PHYSICAL THERAPY EVAULATION AND TREATMENT

I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist at Healthy Seniors Physical Therapy and Wellness (HSPTW) and grant authority to its staff to perform procedures and treatments as deemed necessary and appropriate by the treating therapist. My physical therapy diagnosis and treatment recommendations will be discussed with me and, if at any time I have questions concerning the type of services delivered, I will discuss with my therapist. I understand that there are benefits and risks involved in physical therapy. Risks may include, but not limited to, pain, fall, and/or injury. Consequently, I understand it is my right to discuss the potential benefits and risks with my therapist and I have the right to decline any part of my treatment at any time. Additionally, I grant permission for HSPTW to provide emergency treatment, if it is needed, or to transfer me to a local hospital for emergency treatment.

RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, AND FINANCIAL POLICIES

I hereby authorize release of information necessary to file claims with my insurance company and information to my physician(s). I hereby authorize the below designated party to request and receive the release of health information regarding my treatment. I understand that the identity of the designated parties will be verified by photo ID.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ *Check here if I am paying cash for my services and the following does not apply*. I hereby authorize payment of medical benefits from my insurance company to HSPTW for services rendered by an assignment of benefits. Reasonable efforts will be made to collect insurance proceeds by completing insurance forms and sending them to the insurance company. Completion of the insurance forms and/or the assignment of insurance benefits do not relieve the undersigned of the obligation to pay the amount owed for physical therapy, regardless of insurance coverage.

I hereby accept responsibility for payment for services rendered at the time of service. We accept cash, personal check, money order, Master Card, Visa, American Express and Discover for payment. I further acknowledge there is a $25 fee for returned checks and accounts 30 days past due will be subject to a 5% interest fee per month.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby acknowledge that I have been provided the option to receive a copy of the HSPTW Notice of Privacy Practices. I hereby consent to the use and disclosure of my personal health information for purposes as listed in the Notice of Privacy Practices.

CANCELLATIONS AND MISSED APPOINTMENTS POLICY

I hereby acknowledge there is a 24-hour cancellation notice policy. If I fail to cancel my appointment at least 24-hours prior to the start of my scheduled appointment time on two or more occurrences, HSPTW reserves the right to cancel all remaining appointments and/or discharge me from care.

I permit a copy of this authorization to be used in place of the original.

My signature below acknowledges that I have read and agree with the above information.

_____	_____	_____
Name (printed)	Signature	Date

OFFICE USE ONLY Witness: _____ Date: _____
Name (printed/signed)