Innovative
PHYSICAL THERAPY

Patient Information

Last Name _____ First Name _____ M.I. _____

Phone Home _____ Cell _____ Work _____

Permission to leave a message on your voice mail: YES NO Date of Birth ___ /___ /___

Appointment Reminders: Email _____ or Text _____

Street Address _____ Apt. or PO Box _____

City _____ State _____ Zip Code _____

How did you hear about us? ☐ Physician ☐ Friend ☐ Website ☐ Other _____

Referring Physician _____ Physician Phone _____

Responsible Party/Emergency Contact Information

Last Name _____ First _____

Relationship _____ Day Phone _____ Night Phone _____

Release of Confidential Information for Billing

I, _____ authorize the following person/persons to discuss my medical account, including the procedure, diagnosis, insurance and balance on all services performed.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I have read the "Patient Responsibility and Release of Information" and "Consent to Treat" Forms provided at check-in:

_____ _____

Signature Date

I have read the "HIPPA" Form (Notice of Privacy Practices and How your Medical Information will be used and disclosed) provided at check-in:

_____ _____

Signature Date

Cancellation and Payment Policy

If you need to cancel an appointment, you must call our office one business day prior or you will be charged a $30 cancellation fee. Missing an appointment without calling ("No Show") will also result in a $30 fee on your account. These fees are not be covered by your insurance and must be paid prior to your next appointment. All payments are due at the time of service. This includes copays, deductibles and estimated coinsurance.

_____ _____

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Signature Date

Patient Self Evaluation Form

Name: _____ **Date:** _____

The purpose of this form is to assist you in identifying and clarifying your problem areas and discovering your present level of awareness of your body. It will also serve as a means to acknowledge and note what changes result from the treatments. Please be as complete and in-depth as possible. The privacy of your answers will be respected. The use of this form or the answering of any question is optional.

1. **Present Condition: Pain or Tension**
   a. What are the present symptoms of the problem(s) for which you are seeking treatment?

      Location:

      Frequency:

      Type:

   b. Circle the number indicating your pain level:

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

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

      No pain Unbearable pain

   c. What makes your symptoms worse?

   d. What makes your symptoms better?

   e. Are you taking any medications? What? How much?

   f. What does this pain keep you from doing?

   g. What do you think initially caused your symptoms? When?

2. **Current history of complaint**
   a. Have you ever had anything similar before?

   b. How often has it reoccurred?

   c. Is the frequency or severity increasing?

3. **Postural Concerns**
   a. Do you experience any problems with your posture or movement?

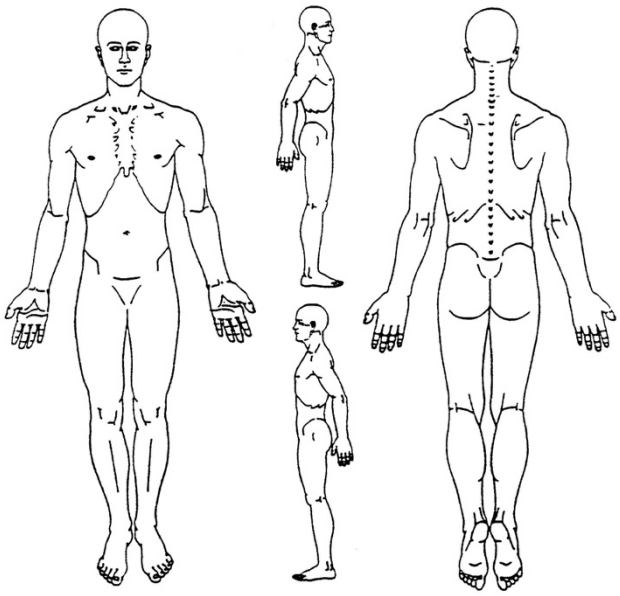
   b. Do you feel this is a result of pain, tension, previous injury, and/or habit patterns?

c. Do you feel this problem limits your daily activities?

4. <u>Please draw on the picture below any pain or symptoms you have using the following symbols:</u>

A = ACHE B = BURNING O = OTHER

P = PINS & NEEDLES N = NUMBNESS R = RADIATING



5. <u>Past Medical History (Note briefly any previous)</u>

a. Accidents or Injuries:

b. Surgeries:

c. Do you have any other diagnosed problems? Birth defects?

d. Are you currently under the care of another physician, psychiatrist, or health professional? Whom?

e. Have you received any previous physical therapy, chiropractic care, or massage therapy? How long ago?

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6. **What goals do you want to achieve with physical therapy?**

7. **What do you expect from physical therapy?**

Medical History

Existing or Relevant Previous Conditions

Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinson's	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High/Low Blood Pressure	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No		

Describe any other conditions

If "Yes" to any of the above, please explain and give approximate dates/Describe any other Conditions

Fall History

Injury as a result of a fall in the past year? ◯ Yes ◯ No Height: _____

Two or more falls in the last year? ◯ Yes ◯ No Weight: _____

Patient is at risk for falls? ◯ Yes ◯ No

Surgical History

Body Region: _____ Surgery Type: _____ Date: _____

Body Region: _____ Surgery Type: _____ Date: _____

Body Region: _____ Surgery Type: _____ Date: _____

_____ _____ _____

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Body Region: Surgery Type: Date:

Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

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Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

○ Currently not taking any medications