ALLIED Physical Therapy

Name: _____ ***DOB:*** _____

Primary Care Physician: _____
Referring Physician: _____

Hand Dominance: Left Right
Are you on a work restriction from your doctor? Yes No
Are you latex sensitive? Yes No
Do you use tobacco? Yes No
Do you have a pacemaker? Yes No
FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No
ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ fatigue
- ❑ fever/chills/sweats
- ❑ nausea/vomiting
- ❑ weight loss/gain
- ❑ difficulty maintaining balance while walking
- ❑ headaches
- ❑ numbness or tingling
- ❑ muscle weakness
- ❑ dizziness/lightheaded
- ❑ heartburn/indigestion
- ❑ difficulty swallowing
- ❑ changes in bowel or bladder function
- ❑ constipation
- ❑ diarrhea
- ❑ shortness of breath
- ❑ fainting
- ❑ cough

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ chest pain/angina
- ❑ high blood pressure
- ❑ circulation problems
- ❑ blood clots
- ❑ stroke
- ❑ anemia
- ❑ bone or joint infection
- ❑ chemical dependency (i.e., alcoholism)
- ❑ depression
- ❑ lung problems
- ❑ tuberculosis
- ❑ asthma
- ❑ rheumatoid arthritis
- ❑ other arthritic condition
- ❑ bladder/urinary tract infection
- ❑ kidney problem/infection
- ❑ sexually transmitted disease/HIV
- ❑ pelvic inflammatory disease
- ❑ thyroid problems
- ❑ diabetes
- ❑ osteoporosis
- ❑ multiple sclerosis
- ❑ epilepsy
- ❑ eye problem/infection
- ❑ ulcers
- ❑ liver problems
- ❑ hepatitis
- ❑ pneumonia

*Are you presently undergoing or have undergone psychological counseling? **YES NO**
*During the past month have you been feeling down, depressed or hopeless? **YES NO**
*During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**
*Is this something with which you would like help? **YES MAYBE NO**
*Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**
Have you ever taken steroid medications for any medical conditions? **YES NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:
_____
_____

What date (roughly) did your present symptoms start?_____

What do you think caused your symptoms? _____

My symptoms are currently: ❑ **Getting Better** ❑ **Getting Worse** ❑ **Staying about the same**

I should not do physical activities that might make my pain worse: ❑ **Disagree** ❑ **Unsure** ❑ **Agree**

Treatment received so far for this problem (chiropractic, injections, etc) _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

Have you ever had this problem before: ❑ **Yes** ❑ **No** **When**_____

Are you currently receiving Home Health Care?_____

Are you being treated at another physical therapy/chiropractic clinic?_____

Have you recieved any physical therapy/chiropractic care this year?_____

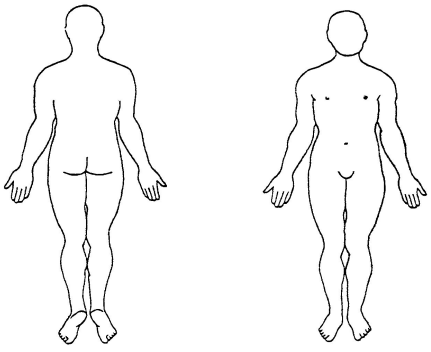
How long did it take for you to feel better? _____

Have you had two or more falls in the last year?_____

With your current condition how does it limit you to perform what you love to do?

Body Chart:

Please mark the areas where you
feel symptoms on the chart to the right with
the following symbols to describe your symptoms:



↓ **Shooting/sharp pain**
O Dull/aching pain
||| **Numbness**
= Tingling

My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

Patient Signature: _____

ALLIED
Physical Therapy

Consent for Treatment

I do hereby consent to such treatment by the authorized licensed personnel of Allied Physical Therapy as may be dictated by prudent medical practice by my illness, injury or condition.

Thank you for allowing us the opportunity to serve you. If you have any questions about the above information or any uncertainty regarding your insurance coverage, please ask for assistance. Kindly sign and date this form to indicate that you understand and agree to the terms of this payment/consent to treat.

Please be advised that we are not a credit guarantor. Therefore, failure to maintain these arrangements may result in the placement of your account with an outside collection agency or attorney for collections. You will remain financially responsible for services rendered, regardless of the payment option selected above. In the event your account becomes delinquent and is therefore default of payment, the patient, legal guardian, or admitting parent will be responsible for the principle amount owed and all reasonable costs associated with the recovery of this debt.

_____ _____

Sign Name Date

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Consentimiento para Tratamiento

Yo por la presente doy consentimiento a tratamiento por el personal licenciado autorizado de Allied Physical Therapy puede ser dictado como por consultorio medico prudente por mi enfermedad, herida o condición.

Gracias por permitirnos la oportunidad de servirle. Si usted tiene cualquier pregunta acerca del su cubierta de seguro medico favor de pedir ayuda. Favor de firmar y fechar esta formulario para indicar que usted comprende y acepta los términos de esta política de pago/consentimiento para ser tratado.

Por favor este advertido que nosotros no somos un garantizador de crédito. Por lo tanto, sino mantiene estos arreglos su cuenta puede ser colocada con una agencia de colección exterior o abogado para colecciones. Usted permanecerá economicamente responsable de servicios dados, sin tener en cuenta la opción de pago seleccionada encima. En el evento que su cuenta se hace delincuente por falta de pago, el paciente,guardián legal, o padre de admisión sera responsable de la cantidad del principal debido y todos los gastos razonables asociados con la recuperación de esta deuda.

_____ _____

Firmar Nombre Fecha

ALLIED Physical Therapy

ACKNOWLEDGEMENT OF PATIENT INFORMATION PRACTICES

I have read and fully understand Allied Physical Therapy's Notice of Patient Information Practices. I understand that Allied Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Allied Physical Therapy!s Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing.

Payment Policy

According to _____(insurance carrier) you have satisfied $_____ of your $_____ (yearly) deductible. The balance of $_____ is payable at the time of service (as based upon your insurance's fee schedule)

- ❏ A co-payment/co-insurance of $_____ or _____% is due at each visit.
- ❏ Worker's Compensation: We will bill your worker's compensation carrier for all charges.
- ❏ Self-Pay: Balance is due in full at the time services are rendered.
- ❏ Motor Vehicle you are responsible for _____% Cancellation Policy

Cancellation Policy

It is our policy to charge a $50 fee for Cancellation or No Show to your appointment. If for any reason you cannot keep your appointment, please call 24 hours prior to your appointment to cancel. This is not covered by your insurance and you will be responsible.

Please Note: It is our policy that the patient will be discharged from our services after three cancellations or no- shows for his/her appointments.

_____ _____

Signature (Guardian if Patient is a minor) **Date**

Spanish Version

Póliza de Pago

De Acuerdo a _____(su seguro) usted ha satisfacido $_____ de su $_____ deducible anual.
El balance de $_____ es pagable en el momento que recibe el servicio, y es basado en los honorario de su seguro.

- ❏ Un co-pago de $_____ o _____% es pagable en cada visita.
- ❏ Compensacion de Trabajo: Facturamos a su seguro de composición por todos los cargos.
- ❏ Pago por cuenta propia: El balance sera pagado en su totalidad en el momento que los servicios sean rendidos.

Póliza de Cancelación

Es nuestra poliza de cargar un honorario de $50 por la Cancelación o no asiste a su cita . Si por alguna razón usted no puede acudir a su cita, favor de llamar con 24 horas antes de su cita para cancelar. Esto no es cubierto por su seguro y usted sera responsable.

Favor de notar: Es nuestra política que el paciente sea dado de baja de nuestros servicios después de tres cancelaciones o ausencias a sus citas

_____ _____

Firma **Fecha**

Medication List

Patient Name:________________________________ Date:__________________

Please List all Medications, including all prescriptions, over the counter medications, herbals, vitamins, minerals, and dietary supplements. Include the dosage, frequency, and administrative method for each medication.

Medication	Dosage	Frequency	Method of Administration
		❏ As Needed ❏ Once Daily ❏ Twice Daily ❏ Three Times Daily ❏ Other:	❏ Oral ❏ Sublingual ❏ Topical ❏ Subcutaneous Injection ❏ Other:
		❏ As Needed ❏ Once Daily ❏ Twice Daily ❏ Three Times Daily ❏ Other:	❏ Oral ❏ Sublingual ❏ Topical ❏ Subcutaneous Injection ❏ Other:
		❏ As Needed ❏ Once Daily ❏ Twice Daily ❏ Three Times Daily ❏ Other:	❏ Oral ❏ Sublingual ❏ Topical ❏ Subcutaneous Injection ❏ Other:
		❏ As Needed ❏ Once Daily ❏ Twice Daily ❏ Three Times Daily ❏ Other:	❏ Oral ❏ Sublingual ❏ Topical ❏ Subcutaneous Injection ❏ Other:
		❏ As Needed ❏ Once Daily ❏ Twice Daily ❏ Three Times Daily ❏ Other:	❏ Oral ❏ Sublingual ❏ Topical ❏ Subcutaneous Injection ❏ Other:
		❏ As Needed ❏ Once Daily ❏ Twice Daily ❏ Three Times Daily ❏ Other:	❏ Oral ❏ Sublingual ❏ Topical ❏ Subcutaneous Injection ❏ Other:
		❏ As Needed ❏ Once Daily ❏ Twice Daily ❏ Three Times Daily ❏ Other:	❏ Oral ❏ Sublingual ❏ Topical ❏ Subcutaneous Injection ❏ Other:

Patient Signature: ________________________________

Reviewd By: _____

ALLIED
Physical Therapy

Dear Patient,

We are pleased that you have chosen Allied Physical Therapy for your physical therapy needs.

Please tell us how you found us:

(Please Check all that Apply)

- ❑ **My Doctor Referred me to Allied Physical Therapy**
- ❑ **A Friend Referred me to Allied Physical Therapy**
- ❑ **I was a Previous Patient**
- ❑ **A Family Member referred me to Allied Physical Therapy**
- ❑ **I heard about Your Services from one of your Physical Therapists**
- ❑ **I learned about Allied Physical Therapy from my Insurance Company**
- ❑ **I learned about Allied Physical Therapy from the Internet**
- ❑ **Other** _____

PLEASE NOTE: If you have an insurance plan that requires a referral/authorization to see a specialist. Please contact your primary care physician or medical group to obtain a referral prior to your appointment date.