ALLIED
Physical Therapy
Getting you back to what you love

Medical History Form

Name: ______________________________

Primary Care Physician: ______________________________

Referring Physician: ______________________________

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

- ❑ fatigue
- ❑ fever/chills/sweats
- ❑ nausea/vomiting
- ❑ weight loss/gain
- ❑ Difficulty Maintaining Balance
- ❑ headaches
- ❑ numbness or tingling
- ❑ muscle weakness
- ❑ dizziness/lightheaded
- ❑ heartburn/indigestion
- ❑ difficulty swallowing
- ❑ changes in bowel/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 (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

Please answer the following questions:

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

Are you currently pregnant or think you might be pregnant? ❑ Yes ❑ No
Are you presently undergoing or have undergone psychological counseling? ❑ Yes ❑ No
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ❑ Yes ❑ No

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Medical History Form Continued...

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

Are you currently receiving Home Health Care from a Nurse or Physical Therapist? ❑ **Yes** ❑ **No**

Have you received any physical therapy/chiropractic care this year? ❑ **Yes** ❑ **No**

Have you had two or more falls in the last year? ❑ **Yes** ❑ **No**

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

____

____

____

Please tell us how you found us:

- ❑ **My Doctor Referred me to Allied Physical Therapy**
- ❑ **A Friend/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** ____

________________________________ ________________________

Signature **Date**

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Medication List

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:

ALLERGIES:
List any medication(s) you are allergic to:

____

____

____

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**

Patient Signature: ______________________________

Reviewd By: ______________________________

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.

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.

______________________________ Signature

________________ Date

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Payment Policy

According to _______________________________ (insurance carrier) you have

satisfied $__________________ of your $_________________ deductible.

- ❑ A Co-payment of $____________ is due at each visit.
- ❑ A Co-insurance of _________% is due at each visit.
- ❑ Workers Compensation: We will bill your worker's compensation carrier for all charges.
- ❑ Motor Vehicle you are responsible for _____%
- ❑ If applicable: Medicare Primary with a Secondary Insurance

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.

Disclosure: 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 principal amount owed and all reasonable costs associated with the recovery of this debt.Kindly sign and date this form to indicate that you understand and agree to the terms of this payment/consent to treat.

______________________________ ______________________

Signature **Date**