

## Medical History Form

Name: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

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

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> fatigue                        | <input type="checkbox"/> numbness or tingling              | <input type="checkbox"/> constipation        |
| <input type="checkbox"/> fever/chills/sweats            | <input type="checkbox"/> muscle weakness                   | <input type="checkbox"/> diarrhea            |
| <input type="checkbox"/> nausea/vomiting                | <input type="checkbox"/> dizziness/lightheaded             | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> weight loss/gain               | <input type="checkbox"/> heartburn/indigestion             | <input type="checkbox"/> fainting            |
| <input type="checkbox"/> Difficulty Maintaining Balance | <input type="checkbox"/> difficulty swallowing             | <input type="checkbox"/> cough               |
| <input type="checkbox"/> headaches                      | <input type="checkbox"/> changes in bowel/bladder function |  |

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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> cancer                           | <input type="checkbox"/> depression                       | <input type="checkbox"/> thyroid problems      |
| <input type="checkbox"/> heart problems                   | <input type="checkbox"/> lung problems                    | <input type="checkbox"/> diabetes              |
| <input type="checkbox"/> chest pain/angina                | <input type="checkbox"/> tuberculosis                     | <input type="checkbox"/> osteoporosis          |
| <input type="checkbox"/> high blood pressure              | <input type="checkbox"/> asthma                           | <input type="checkbox"/> multiple sclerosis    |
| <input type="checkbox"/> circulation problems             | <input type="checkbox"/> rheumatoid arthritis             | <input type="checkbox"/> epilepsy              |
| <input type="checkbox"/> blood clots                      | <input type="checkbox"/> other arthritic condition        | <input type="checkbox"/> eye problem/infection |
| <input type="checkbox"/> stroke                           | <input type="checkbox"/> bladder/urinary tract infection  | <input type="checkbox"/> ulcers                |
| <input type="checkbox"/> anemia                           | <input type="checkbox"/> kidney problem/infection         | <input type="checkbox"/> liver problems        |
| <input type="checkbox"/> bone or joint infection          | <input type="checkbox"/> sexually transmitted disease/HIV | <input type="checkbox"/> hepatitis             |
| <input type="checkbox"/> chemical dependency (alcoholism) | <input type="checkbox"/> pelvic inflammatory disease      | <input type="checkbox"/> 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

**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?***

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**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 \_\_\_\_\_

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**Signature**

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**Date**

### 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
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> Three Times Daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous Injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> Three Times Daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous Injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> Three Times Daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous Injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> Three Times Daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous Injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> Three Times Daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous Injection <input type="checkbox"/> Other:

**ALLERGIES:**

List any medication(s) you are allergic to:

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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.

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Signature

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Date

## **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**