PATIENT MEDICAL HISTORY

Name: _____ City: _____

Date of Birth: _____ State: _____Zip Code: _____

Height: ____ ft. ___ in. Weight: _____ Phone number: _____

Street Address: _____ Email: _____

Emergency Contact: _____

Emergency Contact Phone Number: _____

What problem or health condition brings you here? _____

_____

Date of injury/onset of this issue/date of surgery? _____

Have you had this issue before? ☐YES | ☐NO

If yes, did you receive therapy for it previously? ☐YES | ☐NO

This issue started (check one)…☐GRADUALLY | ☐ABRUPTLY

If you had this before, when did you last have this issue (approximately what year)? _____

Have you had imaging prior to starting Physical Therapy? Check all that apply.

☐X-Ray ☐CT scan

☐MRI ☐Other _____

Are your symptoms (check one box)…

☐Getting better ☐Not changing ☐Getting worse

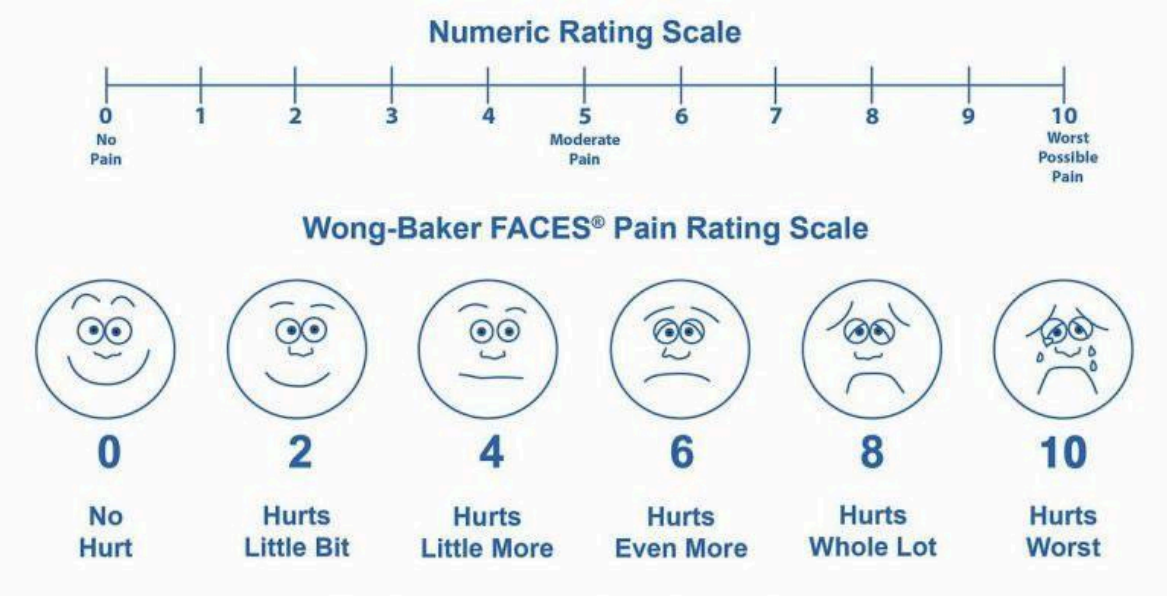
Please describe the **ONE** location of where you have the MOST pain:_____

If there are multiple painful areas, list them in order of most painful to least painful:

_____

_____

Please use the pain scales below to help us understand your pain intensity, if you have pain.



Please rate the **WORST** your pain ever gets, using the scale above (provide number):_____

Please rate your **CURRENT** level of pain, using the scale above (provide number):_____

Please rate the **BEST** your pain gets, using the scale above (provide number):_____

Are any of the following **aggravating factors**? Check all that apply.

☐Sitting	☐Going up/down stairs	☐Bending
	☐Lifting/Carrying objects	☐Sit to Stand
☐Walking	☐Rolling Over in Bed	☐Lying down

If you are having neck or back pain, does that pain **radiate** into any extremity? ☐YES │ ☐NO

If yes, describe where you have radiating pain? _____

Are you dizzy? ☐YES │ ☐NO

If yes, when are you the most dizzy? _____

Have you had a fall in the past year? ☐YES │ ☐NO If yes, were you injured? ☐YES │ ☐NO

If yes, how many falls have you had in the last year? _____

Do you have or ever had any of the following health conditions? Check all that apply.

☐Alzheimer's/Dementia
☐High/Low Blood Pressure
☐Lupus
☐Stroke (CVA / TIA)
☐Current Infection
☐Depression
☐Diabetes, Type 1 or Type 2
☐Dizzy Spells / Vertigo
☐Fibromyalgia
☐Anxiety
☐History of Cancer
☐Immunosuppression
☐Cardiovascular Disease / Circulation problems
☐Multiple Sclerosis
☐Obesity
☐Osteoarthritis
☐Osteoporosis
☐Parkinson's
☐Rheumatoid Arthritis
☐Traumatic Brain Injury

Do you smoke? ☐YES | ☐NO

Do you take any medications (prescription or over the counter)? ☐YES | ☐NO
If yes, please list type and dosage below or provide a separate list.

_____

_____

_____

_____

_____

What are your goals for physical therapy? Check all that apply.

☐Improve home / self-care activities
☐Return to work
☐Improve mobility / walking activities
☐Decrease or eliminate pain / discomfort
☐Improve recreation / sports activities
☐Improve strength / balance
☐Other (please describe):_____
_____

To the best of my knowledge, the information above is complete and factual.

Patient Signature: _____Today's Date: _____

Patient Consent & Financial Agreement

Authorization for Treatment: Physical therapy services offered at FYZICAL include, but are not limited to evaluation techniques, soft tissue and manual therapy techniques, heat, cold, electrical stimulation, electrical and vibration modalities, stretching activities, strengthening exercises, traction, and the use of gym and/or other fitness equipment.

I have been informed that if any soft tissue technique, particularly Instrument Assisted Soft Tissue Mobilization (IASTM) technique / active release/ cross-fiber friction mobilization, are used, it may cause bruising, redness and/or tenderness in the region that is/was treated. If the technique is too uncomfortable, I will bring it to the attention of my physical therapist so that the procedure can be modified or ceased.

I understand that I have the right to refuse any physical therapy service(s) offered if I so choose. I understand that physical therapy may involve some risk, and I hereby release FYZICAL from liability now or in the future.

I understand that FYZICAL works with accredited academic institutions, through clinical student affiliations, to provide healthcare professionals in training with hands-on patient care experiences and opportunities to apply learned skills to patient care. I understand that these individuals may be involved in my care.

Assignment of Insurance Benefits and Release of Information: I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits and insurance payments be made to FYZICAL and its affiliates. I authorize payment of medical benefits to FYZICAL and its affiliates.

Personal Valuables/Dependents/Visitors: It is understood and agreed that FYZICAL is not responsible for loss or damage to any personal valuables or properties. In order to maximize safety, if children or other family members are present, please keep them off the exercise equipment in order to prevent injuries.

Financial Agreement: I, the undersigned agree, to be responsible for all deductibles, copayments, coinsurance and non-covered portions of services performed. I understand that FYZICAL and its affiliates bill insurance companies as a courtesy. I understand that all co-payments, coinsurance, and deductibles are due at the time of service. I understand that benefits quoted to me are only an estimate. I understand that it is my responsibility to know and understand my health plan. I understand that FYZICAL is not responsible for any inaccurate information they receive from my insurance. I understand that it is my responsibility to obtain necessary referrals (if required) from my doctor prior to coming to FYZICAL. Should my account be referred to an agency or attorney for collections, I may be responsible for any and all attorney and collection fees charged to FYZICAL associated with collecting the debt. I agree to pay an insufficient funds fee for any returned checks.

Credit Card/Debit Card Payments: By signing this form, I authorize FYZICAL to keep my credit/debit/HSA card on file for future payments. I also authorize FYZICAL to charge my card on file if I have any outstanding balances on a monthly basis or to collect final payment after my plan of care has been completed. You have the option to decline this convenience and physically produce your card (or pay with cash or check) at every visit. If you would like to decline this option, please initial here: _____

Release of Protected Health Information: I authorize the release of information acquired in the course of my treatment including but not limited to medical records, electronic media, and oral communications, to my insurance company representatives, primary care physician, referring physician, other third-party payers and/or the following individuals I have listed below (e.g., spouse, family member, friend):

Name:_____ Relationship:_____

A Notice of Privacy Practices, a document that describes how your medical information may be used and disclosed, is included in your New Patient Folder that will be provided at your initial evaluation.

Appointment Confirmation Communication: I authorize phone, e-mail, and/or text messages regarding my treatment and appointments to be left with persons or machines at the phone numbers provided.

Home Health Services: Receiving Medicare-provided services at home at the same time as outpatient physical therapy services will impact your financial obligations. By signing this form, I am verifying that I:

- Am not currently receiving any home health services (e.g., nursing services, wound care, physical therapy, etc.).
- Have not received any home health services (e.g., nursing services, wound care, physical therapy, etc.) in the last week.
- Am not going to physical therapy elsewhere (Even for a non-related diagnosis) at the present time.

My signature below acknowledges the above consent and agreeing to the terms of this document in its entirety except where noted above.

_____ _____/_____/_____

Patient or Legal Guardian's Signature Date

Cancellation & No-Show Policy

We strive to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient with a specific therapist in order to minimize your waiting and assure continuity of your treatment. Your consistent attendance of the planned treatment regimen is paramount to your full recovery. We believe that this policy is necessary for the benefit of all our patients, so that we may continue to provide high quality treatment and service to everyone. All of us at FYZICAL appreciate your adherence and cooperation with this policy. We are here to help you attain all of your goals and optimize your return to all of your highly anticipated activities.

What is considered a cancellation? An appointment that Is canceled **less than 24 hours** from the appointment time is considered a canceled appointment. If you are unable to make your appointment, **please provide more than a 24 hour notice** so that we may offer your appointment time to another patient In need.

What is considered a No Show? When a patient does not show up for a scheduled appointment.

Will I be charged a fee If I cancel less than 24 hours or If I no show for my appointment? There is a potential $25 penalty that may be assessed. The fee Is not billable to Insurances. The fee will be **due on or before the next appointment.** To avoid the fee, see if an earlier or later appointment time is available that day or give more than 24 hours notice.

Are there exceptions? Yes! We understand unforeseen things do happen and we most definitely do not want patients coming to an appointment If they are Ill or feel unsafe to drive. **A fee will not be charged** for certain circumstances, but the occurrence **will count towards your cancellation or no-show count.**

What happens If I continue to cancel or no show for my appointments? If you cancel your appointment or no show **3 times In a 30 day span**, we will place you on a "Same Day Scheduling" option. At that point you will need to call the day you are available to attend therapy to see if we have an opening. No appointments will be made days in advance.

What if I'm going to be late for my appointment? If you are more than **10 minutes** late, we may need to modify your appointment time (if we are able to do so) or cancel your appointment.

By signing below, I agree to adhere to the above policy and will fully commit to my plan of care so that I can reach my goals!

_____ _____/_____/_____

Patient or Legal Guardian's Signature Date