Stillpoint Physical Therapy

PATIENT INFORMATION

LAST NAME	FIRST	M.I.	DATE OF BIRTH	SEX

HOME ADDRESS	CITY	STATE	ZIP	HOME PHONE

MARITAL STATUS ☐ Single ☐ Married ☐ Other

EMPLOYMENT ☐ FT ☐ PT ☐ Student

EMPLOYER NAME / SCHOOL NAME	TITLE/POSITION

WORK ADDRESS	CITY	STATE	ZIP	WORK PHONE

EMAIL	PREFERRED CONTACT NUMBER

REFERRING PHYSICIAN INFORMATION

LAST NAME	FIRST	M.I.

ADDRESS		STATE	ZIP	PHONE

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION

LAST NAME	FIRST	M.I.

HOME ADDRESS	CITY	STATE	ZIP	HOME PHONE

RELATIONSHIP ☐ Emergency Contact ☐ Parent ☐ Guardian

WORK PHONE

PARENT OR GUARDIAN EMAIL ADDRESS

REASON FOR TODAY'S VISIT

INJURY/CONDITION RELATED TO YOUR: ☐ JOB ☐ CAR ☐ HOME ☐ OTHER ACCIDENT

DATE OF ACCIDENT / INJURY / FIRST SYMPTOM: _____

PLEASE DESCRIBE INJURY / ACCIDENT / ILLNESS: _____

_____

FINANCIAL AGREEMENT

YOU ARE FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED. PAYMENT IS TO BE MADE IN FULL AT THE TIME OF THE VISIT. IF REQUESTED, A "SUPERBILL" WILL BE PROVIDED. THIS CAN BE SUBMITTED DIRECTLY TO YOUR INSURANCE COMPANY FOR REIMBURSEMENT.

24-HOUR CANCELLATION POLICY

YOU WILL BE CHARGED FOR MISSED APPOINTMENTS AND CANCELLATIONS WITH LESS THAN 24 HOURS NOTICE.

I HAVE READ AND AGREE TO THE ABOVE

NAME_____SIGNATURE _____ DATE _____

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MEDICAL HISTORY SCREEN

Patient's Name _____Date _____

Activities / Sports / Hobbies: _____

_____

_____

Have you or any immediate family member been told you/they have:

	SELF		FAMILY	
Cancer	☐ Yes	☐ No	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	☐ Yes	☐ No
Angina/Chest Pain	☐ Yes	☐ No	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	☐ Yes	☐ No

Have you had or do you experience:

Recent Change in Your Health	☐ Yes	☐ No
Nausea/Vomiting	☐ Yes	☐ No
Fever/Chills	☐ Yes	☐ No
Unexplained Weight Loss	☐ Yes	☐ No
Dizziness or Falls	☐ Yes	☐ No
Changes in Bowel or Bladder Function	☐ Yes	☐ No

Date of last Physical Examination:

_____

_____

Do you have a history of:

Joint replacements/Implants	☐ Yes	☐ No
Allergies/Asthma	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Breathing Problems	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
Seizures	☐ Yes	☐ No

Are you currently:

Pregnant	☐ Yes	☐ No
Depressed	☐ Yes	☐ No
Under Stress	☐ Yes	☐ No

Are your symptoms:

- ☐ Getting Worse
- ☐ Remaining the Same
- ☐ Improving

How well do you sleep at night:

- ☐ Fine
- ☐ Moderate Difficulty
- ☐ Only with Medication

List Medications

_____

_____

_____

What are your goals for therapy?

_____

_____

_____

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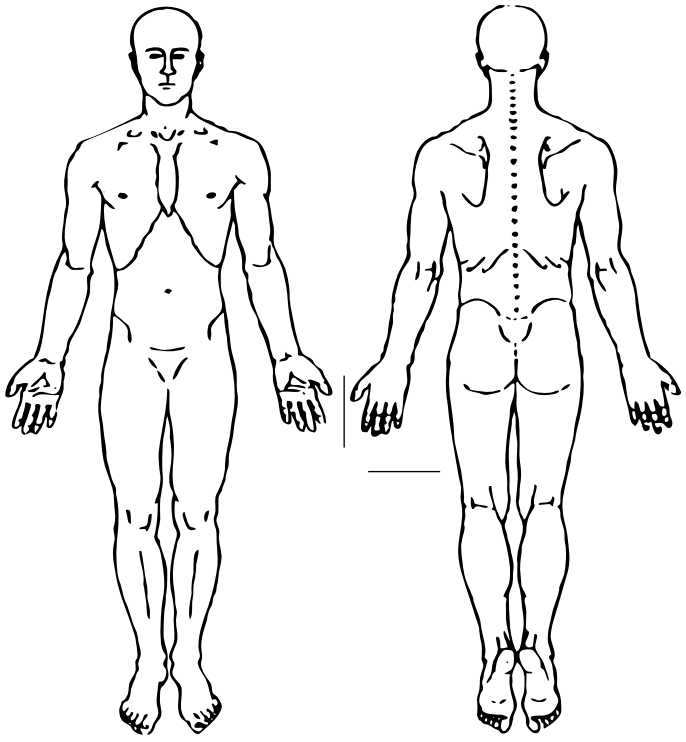
Please indicate the areas where you are experiencing pain/symptoms. Use the symbols in the table below to describe your pain/symptoms.

////	Pain
XXXX	Burning
0000	Pins and Needles
====	Numbness



Other complaints:

_____
_____
_____
_____
_____

If you are having pain, rate the severity on a scale of 0-10, where 0 is no pain and 10 is the most severe pain (circle a number on each line):

At Best:	0	1	2	3	4	5	6	7	8	9	10
At Worst:	0	1	2	3	4	5	6	7	8	9	10
At This Time:	0	1	2	3	4	5	6	7	8	9	10

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CONDITIONS & CONSENT FOR PHYSICAL THERAPY

Informed Consent for Treatment:
The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Potential benefits may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Potential risks: I understand I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

No warranty: I understand that my physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

I have read the above information and I consent to physical therapy evaluation and treatment. By initialing above and signing below, I acknowledge that I have read, understood and will abide by the conditions and policies noted on this consent form.

_____ _____
Print name Date

_____ _____
Patient's signature Therapist signature / Date

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HIPAA REGULATIONS

Privacy Practices
The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Legal Duty
The law requires us to: 1) Keep your medical information private. 2) Give you notice describing our legal duties and privacy practices. 3) Notify you of any changes in our privacy practices.

Use and Disclosure
To follow are different ways that we are permitted to use and disclose medical information. We will not use or disclose any medical information not listed without specific written authorization from you.

Treatment: We may use medical information about you to provide you with medical treatment or other services related to your care. We may disclose medical information about you to doctors, nurses, technicians or other people involved in your care. We may also share medical information about you to your other health care providers to assist them in treating you.

Billing: If you submit an invoice to your health plan for reimbursement, your health plan will be informed of dates of services and the procedurue codes on that invoice. We will not use or disclose any medical information to your health plan without specific written authorization from you.

If you have any question about any of our policies or your rights, please feel free to ask us.

Your signature below indicates your understanding and acceptance of the above privacy practices.

_____ _____
Patient's signature Date

_____
Print name

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