First_________________________________**M.I.**_______**Last**_________________________________**DOB**______

Street_________________________________**City**_________________________________ **State**______ **Zip**________

Email____ **Male** ❒ **Female** ❒

If patient is a minor, enter legal guardian or guarantor information below

First_________________________________M.I._______Last_________________________________DOB_______

❒ **Check if guardian/guarantor address is same as patient address**

Street_________________________________ City_________________________________ State_______Zip_______

Home Phone (________) _______________**Work Phone** (________) _______________**Cell Phone** (________) _______________

Patient Occupation_________________________________**Employer**_________________________________

Emergency Contact_________________________________**Phone** (________) ____________**Relationship**___________________

Referring Physician_________________________________**Primary Care Physician (PCP)**_________________________________

Diagnosis (or body part to be treated)____ **Left** ❒ **Right** ❒

Recent Surgery Yes ❒ - **Surgical Date**________________________ **No** ❒

Did you receive Home Healthcare Services? Yes ❒ No ❒

Have You Been Discharged From Home Healthcare Services? Yes ❒ - Date of Discharge___________________________ No ❒

Is this injury as a result of a motor vehicle accident (MVA)? Yes ❒ **No** ❒

Is this injury as a result of a work-related accident? Yes ❒ **No** ❒

Have you received any therapy services this year? Yes ❒ **No** ❒

If yes, please list what type and number of treatments____

How did you hear about ProForm Physical Therapy?____

Patient Initials______

Patient Consent

The patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") by ProFrom Physical Therapy, LLC in order to carry out treatment, payment, or healthcare operations. The patient should review ProForm Physical Therapy, LLC Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and the patient has the right to review such notice prior to signing this consent form.

Patient retains the right to request that ProForm Physical Therapy, LLC further restricts how his/her protected health information is used or disclosed to carry out treatment, payment or health care operations. ProForm Physical Therapy, LLC is not required to agree to such requested restrictions; however, if ProForm Physical Therapy, LLC does agree to patient's requested restriction(s), such restrictions are then binding on ProForm Physical Therapy, LLC.

ProForm Physical Therapy, LLC may refuse to treat patient if he/she (or an authorized representative) does not sign this consent form. If patient (or authorized representative) signs this consent form and then revokes consent, ProForm Physical Therapy, LLC has the right to refuse to provide further treatment to patient as of the time of revocation.

I have read and understand this information, I have received a copy of the Notice of Privacy Practices and I am the patient or am authorized to act on behalf of the patient to sign this document verifying consent to the above stated terms.

I have read and understand this information, I have received a copy of the Notice of Privacy Practices and I am the patient or am authorized to act on behalf of the patient to sign this document verifying consent to the above stated terms.

Patient Signature:____**Date:**______________

Guardian/Guarantor (If under 18 years old)

Health Questionnaire
(Pain & Symptoms)

Is your pain? ❒ Intermittent ❒ Constant

When is your pain the worst? ❒ Morning ❒ Afternoon ❒ Evening ❒ Nighttime

When is your pain the best? ❒ Morning ❒ Afternoon ❒ Evening ❒ Nighttime

Does the pain affect your sleep? ❒ Yes ❒ No

Circle the number that rates your pain <u>at worst</u>:

None 0 1 2 3 4 5 6 7 8 9 10 Severe

Circle the number that rates your pain <u>currently</u>:

None 0 1 2 3 4 5 6 7 8 9 10 Severe

Circle the number that rates your pain <u>at best</u>:

None 0 1 2 3 4 5 6 7 8 9 10 Severe

Please Describe:

What makes your pain better?

____

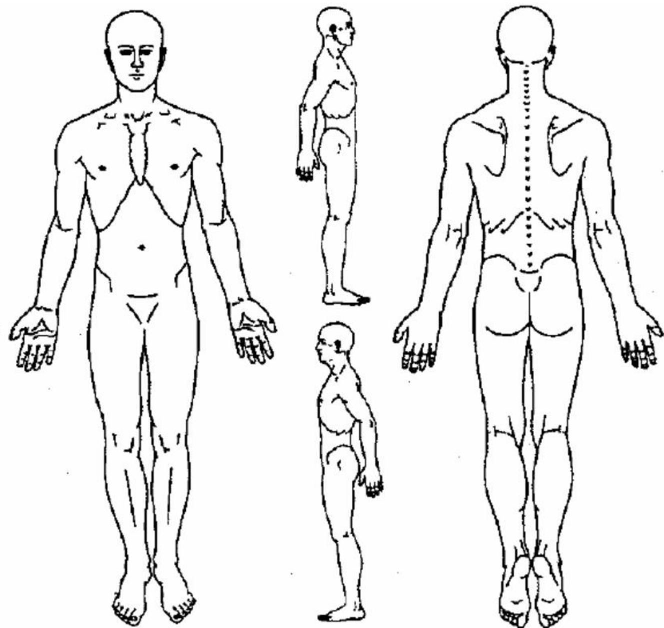
What makes your pain worse?

____

Due to my symptoms/injury I am unable to/have difficulty with?______________________________________

My Goal(s) with Physical Therapy? ____

Please Indicate below where your symptoms are located:



Do symptoms increase with:

Coughing ❒ Yes ❒ No

Sneezing ❒ Yes ❒ No

Bowel Movements ❒ Yes ❒ No

Do you have any numbness?

❒ Yes ❒ No

If yes, where? ______________________

Tingling/Pins/Needles ❒ Yes ❒ No

If yes, where? ______________________

Patient Initials______

Health Questionnaire
(Continued)

Have you ever been told you have any of the following?

Condition	Yes	No	Condition	Yes	No
Cancer	Yes ❒	No ❒	Ulcers	Yes ❒	No ❒
Heart disease	Yes ❒	No ❒	Infectious diseases	Yes ❒	No ❒
High Blood Pressure	Yes ❒	No ❒	Lung disease	Yes ❒	No ❒
Angina/Chest Pain	Yes ❒	No ❒	Hepatitis	Yes ❒	No ❒
Asthma	Yes ❒	No ❒	Anemia	Yes ❒	No ❒
Diabetes	Yes ❒	No ❒	Allergies	Yes ❒	No ❒
Osteoporosis	Yes ❒	No ❒	Fibromyalgia	Yes ❒	No ❒
Thyroid problems	Yes ❒	No ❒	Kidney disease	Yes ❒	No ❒
Rheumatoid arthritis	Yes ❒	No ❒	Stroke	Yes ❒	No ❒
Osteoarthritis	Yes ❒	No ❒	Seizures/Epilepsy	Yes ❒	No ❒
Depression	Yes ❒	No ❒	Smoker	Yes ❒	No ❒

Currently, are you experiencing any of the following? (Check all that apply):

❒ Fever/chills/sweats ❒ Poor balance (falls) ❒Unexplained weight loss

❒ Numbness/tingling ❒ Changes in appetite ❒Difficulty swallowing

❒ Depression ❒ Shortness of breath ❒ Changes in bowel or bladder function

❒ Dizziness ❒ Nausea/vomiting ❒ Night pain ❒ Headaches

Have you had surgery within the last 5 years? Yes ❒ No ❒
If yes, please explain____

Do you have a history of any major accidents or falls? Yes ❒ No ❒
If yes, please explain____

Have you been treated for any other condition in the past 12 months? Yes ❒ No ❒
If yes, please explain____

Are you presently taking any medications? Yes ❒ No ❒
If yes, please provide medication list, or list below:

____

Any additional medical conditions? Yes ❒ No ❒
If yes, please explain____

Patient Initials______

Acknowledgement of Office Policies

Thank you for choosing ProForm Physical Therapy, LLC as your provider. The following are ProForm Physical Therapy, LLC policies governing appointment scheduling, financial terms, and information releases. **Please read carefully** before signing and be sure to ask questions you might have before signing the document.

Attendance Policy: We at ProForm Physical Therapy, LLC are glad to accept insurance assignment on your behalf. However in order to help ensure that your insurance company pays for the care you receive here, it is important that you adhere to the recommended care program. We require a **24-hour cancellation notice** for all appointments. ProForm Physical Therapy, LLC reserves the right to charge a fee of **$50.00** for all missed appointments ("no shows") and appointments which, absent of compelling reason, are not cancelled with a 24-hour advance notice. If there is the presence of multiple "no shows" in any (4) week period without notifying ProForm Physical Therapy, LLC (emergencies considered), you may be discharged from care and your file may be closed.

Assignment of Payment: I hereby authorize my insurance company to pay direct to ProForm Physical Therapy, LLC, any monies due on my account for professional services rendered.

Acknowledgement and Understanding: It is further understood that I, the undersigned, agree to pay the full amount of the charges should my condition be such that it is not covered by my policy, or if, for any reason, the insurance company refused to pay my remaining balance.

Private Health Insurance: As a courtesy, ProForm Physical Therapy, LLC will submit to your insurance carrier. If you have secondary insurance, which you request be billed in the place of making co-payments, you assign those benefits to us and we will bill the secondary insurance directly. I understand that I am responsible for whatever fees my insurance company does not pay on my claim.

HMO Coverage: If you belong to an HMO plan, which required a referral from your primary care physician, it is your responsibility to obtain the referral. If the referral is not supplied and we do treat you, it is your responsibility to pay your bill when the insurance denies the claim.

Authorization to Release Information: I authorize ProForm Physical Therapy, LLC to release any information pertinent to my case to any insurance company to facilitate collections on my remaining balance.

Patient Request for Records: I instruct the release of all medical, hospital, or surgical records pertinent to my care, including but not limited to exams, special tests, x-rays, or lab results.

Protection of Your Information: ProForm Physical Therapy, LLC will safeguard your information according to prudent security standards. We maintain physical, electronic, and procedural safeguards designed to comply with federal guidelines to guard your information against unauthorized access or use. ProForm Physical Therapy, LLC staff is subject to a code of ethics and other policies that require maintaining the confidentiality of information. We limit the collection, use, and retention of your information to what we believe is necessary to provide you with exceptional service.

Consent for Treatment: I, the undersigned, give the professional staff at ProForm Physical Therapy, LLC my permission to evaluate and treat my injury. I further understand that no guarantee or promise has been made to me concerning the results of treatment. I further understand that the waiting room is a common area accessed by patients and as a result there may be incidental contact with personal health information.

I certify that I have read and understand all appointment and office policies listed above.

Patient Signature:____ **Date:**_______________________

Guardian (If under 18 years old)

Name (Please Print):____