

PATIENT INFORMATION

Full Name: _____ Gender: Male/ Female/ Other DOB: ___/___/___
 Mailing Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Home/ Work/ Cell 2nd Phone: _____ Home/ Work/ Cell
 Email Address: _____ Reminders for Appointments? Text/ Email (Circle)
 Employer: _____ Occupation: _____ Last 4 digits of SSN: _____
 Emergency Contact: _____ Relationship: _____ Phone: _____

CURRENT CONDITION/INJURY INFORMATION

Injury Date: _____ Type (Circle what applies): Work Comp Motor Vehicle Sports Fall Other: _____
 Have you had any imaging? (Circle what applies): MRI CT Scan X-ray Other: _____
 What were the results, if any? _____
 Did you have surgery? (Circle) Yes/ No If yes, Surgery Date? _____
 Have you had 2 or more falls in the past year? (Circle) Yes/ No

CARE PROVIDER INFORMATION

Referring Physician: _____ Primary Care Physician: _____
 How did you hear about us? (Circle all that applies): Physician Friend Facebook Internet Driving by Other: _____

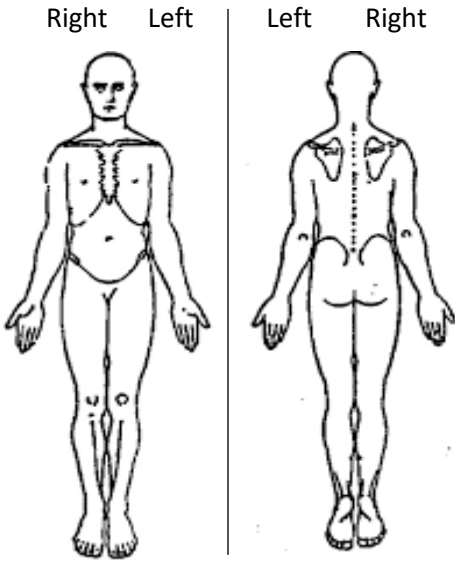
INSURANCE INFORMATION

<u>Primary Insurance</u>	<u>Secondary Insurance</u>
Insurance Company: _____	Insurance Company: _____
Policy Holder's Name: _____	Policy Holder's Name: _____
Relationship to Patient: _____	Relationship to Patient: _____
Policy Holder's DOB: _____	Policy Holder's DOB: _____

- Please review and check the following statements:**
- I authorize the release of any medical information necessary to process this claim and to other medical practitioners directly involved with my care.
 - I authorize payment of medical benefits/Government Benefits to the Physical Therapy provider for service described.
 - If insurance company or other 3rd party payor does not make full payment on this claim, I will be responsible for charges accrued for services provided. (Note: This statement does not apply to Medicare/Medicaid patients.)
 - I have received the Notice of Privacy Practices packet.
 - I consent to examination and/or treatment by my attending therapist

Patient (or Authorized Person's) Signature: _____ **Date:** _____

SYMPTOM INFORMATION



Identify your injury/symptomatic area by circling it on the images to the left.

On a scale from 0-10, rate your **highest** pain level. (Circle what applies)

0 1 2 3 4 5 6 7 8 9 10

On a scale from 1-10, rate your **current** pain level. (Circle what applies)

0 1 2 3 4 5 6 7 8 9 10

What activities are you having difficulty performing due to your pain?

Which of these activities results in the highest pain?

Other complaints/symptoms: (swelling, stiffness, weakness, etc.)

In the past week, have your symptoms:

- Worsened
 Stayed the same
 Improved

PAST MEDICAL HISTORY

Do you have history of any of the following? (Check what applies)

- | | | |
|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes: Type 1 or 2 | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> Muscular Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema/Bronchitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Blood Pressure: High or Low | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Fractures: _____ | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cardiac Conditions: _____ | <input type="checkbox"/> Headaches | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Immunosuppression | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Metal Implants | _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> MRSA | _____ |

Allergies: _____

Past Surgeries: _____

Medication/Supplements List: _____

CANCELLATION & NO SHOW POLICY**Please read the following:**

We understand that situations arise in which you must cancel your appointment. We request that if you must cancel your appointment you provide more than **24 hours notice**. This will enable another patient who is waiting for an appointment to be scheduled in that time slot. Appointments that are cancelled with less than 24 hours notice may be subject to a **\$50.00** cancellation fee.

Patients who do not show up for their appointment without a call to cancel an appointment will be considered a **NO SHOW**. A **\$50.00 NO SHOW** fee will be assessed. Patients who No Show two or more times may have scheduling restrictions for future appointments.

Patients who show up **15 minutes or later** to their scheduled time will be kindly asked to reschedule their appointment.

The Cancellation and No Show fees are the sole responsibility of the patient. We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived with management approval. Questions about cancellation and no show fees should be directed to Lauren, our billing specialist.

I am requesting a copy of this policy (circle one): Yes No

Please sign acknowledging that you have read, understand, and agree to this Cancellation & No Show Policy.

Signature of Patient or Patient Representative: _____ **Date:** _____

Patient Name (Please Print): _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY**Health Information Privacy Notice. Please read and fill out the information below:**

I hereby acknowledge that I received a copy of the Notice of Privacy Practices packet and give all parties of Johnston Physical Therapy/Elevate Physical Therapy permission to contact me via (Check all that apply):

_____ Cell Phone _____ Email
_____ Home Phone _____ Voicemail
_____ Work Phone _____ Text Message

My signature below indicates that I have been given an opportunity to read the Notice of Privacy Practices and to have any questions answered before signing.

Signature of Patient or Patient Representative: _____ **Date:** _____