PERSONAL INFORMATION			
Patient Name	Date of Birth		
Employed? Y N Occupation?	Full Time	Part Time	Retired
Have you **already had** physical therapy in an outpatient office during this calendar year? Y N When? For how long? For What Reason?			
Primary Care Physician			
Referring Physician			
When are you scheduled to see your doctor again?			

PHYSICAL THERAPY INFORMATION		
What is your reason for seeing us today?		
Date of Injury or Change of Condition/Status:		
Treatment side: Rt Lt	Height: _____ft. _____in.	Weight:_____lbs.
History of Falls? Y N Date of Fall(s)		
Are you exercising at home? Y N If yes, what type?		
Any Pertinent Diagnostic Tests Performed: (List dates and types)		
Any Pertinent Surgery Performed: (List dates and types)		
Any Functional Limitations? (Circle all that apply) Sleep/Self Care/Reaching/Pushing/Pulling/Lifting/Carrying/Bending/Sitting/Standing/Walking Squatting/Other(specify)		
Aggravating Factors (circle all that apply) Sitting/Standing/Walking/Stairs-up /Stairs-down/Sit to stand/Bending/Laying/Coughing Sneezing/Other(specify)		
How do you manage your pain? Ice Heat Other(specify)		
Patient Goals/What would you like to gain from PT?		

MEDICAL HISTORY					
Condition	**Yes**	**No**	**Condition**	**Yes**	**No**
Heart Disease			Fibromyalgia		
High Blood Pressure			Inflammatory Arthritis		
Pacemaker			Osteoarthritis		
Diabetes			Osteoporosis		
Stroke			Scoliosis		
Neurological Disorders			Mental Health		
Seizures			Hearing Impairment		
Asthma			Visual Impairment		
COPD			Allergies		
Smoker			Pregnant		
Cancer/Chemotherapy/Radiation			Major Surgeries		
Immunocompromised			Other (Specifiy)		
Covid Vaccinated					

MEDICATIONS	Dosage	Frequency

*To the best of my knowledge, all proceeding answers are true and correct. If I ever have any change in my health or medications, I will inform my therapist at my earliest convenience.

PRINTED NAME:_____ **SIGNATURE:**_____

DATE:_____

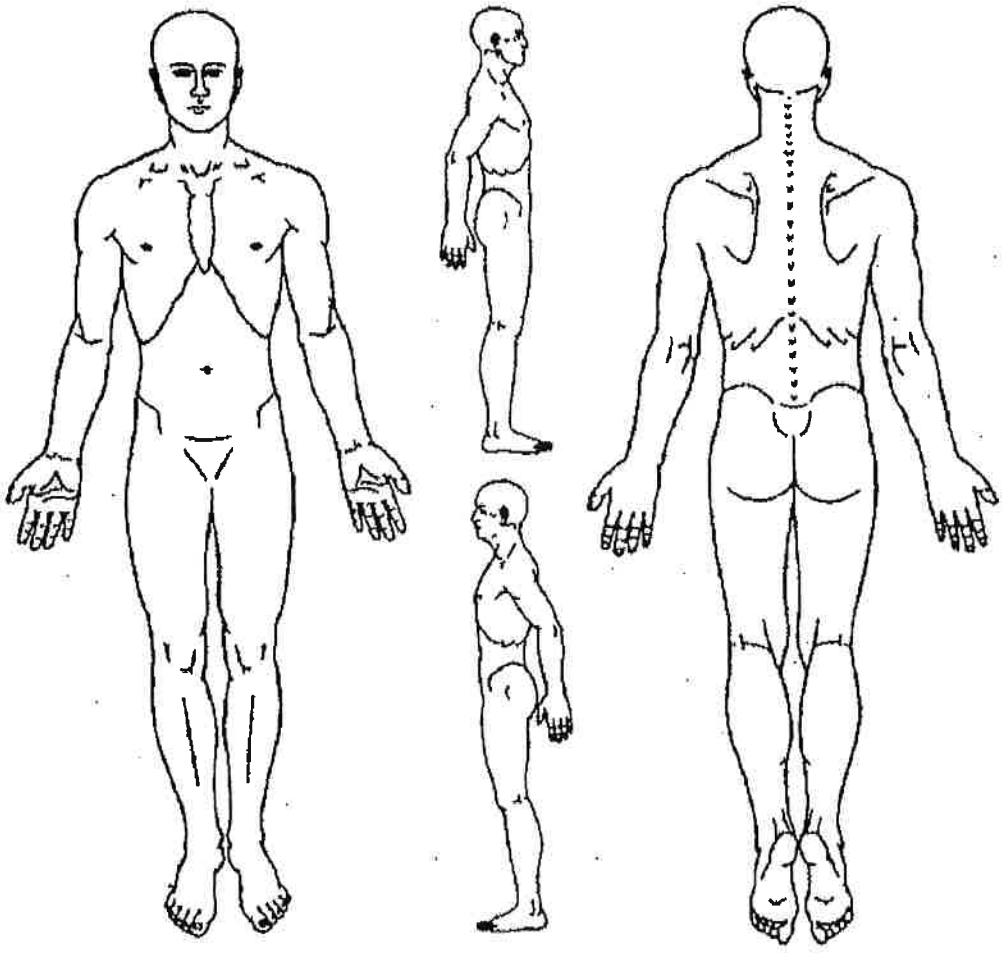
Name:_____
Date:_____

PAIN DIAGRAM

On the diagrams below mark where you are experiencing pain, right now, by using the letters below to indicate the type and location of your sensations.

Key:

A = Aching B =Burning N = Numbeness P = Pins & Needles S = Stabbing O = Other



Rate your pain levels: 0=No Pain, 5=Moderate Pain, 10=Severe Pain

At Worst	0	1	2	3	4	5	6	7	8	9	10
Right Now	0	1	2	3	4	5	6	7	8	9	10
At Best	0	1	2	3	4	5	6	7	8	9	10

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Patterson Physical Therapy may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Patterson Physical Therapy complies with HIPPA laws regarding your PHI. I have the right to request a comprehensive copy of Patterson Physical Therapy's *Notice of Privacy Practices* prior to signing this consent. I understand that Patterson Physical Therapy reserves the right to revise its *Notice of Privacy Practices* at any time.

With my consent, Patterson Physical Therapy may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to clinical care.

With my consent, Patterson Physical Therapy may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as patient statements.

I understand that my PHI will be used in accordance with the policies outlined under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and certifications.

I have the right to request in writing that Patterson Physical Therapy restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my restrictions, but if it does, it is bound by this agreement.

I understand that I have the right to revoke my consent in writing for use and disclosure of my PHI to carry out TPO except to the extent that the practice has already made disclosures in reliance upon my prior consent.

I understand that Patterson Physical Therapy can support my care with a telemedicine visit which may include video conference meeting and/or phone conference conversation. I understand that my telemedicine visit(s) will follow all HIPAA regulations. Any telemedicine visit(s) will be billed to my insurance and I will be responsible for any copayments or coinsurances that apply.

I understand that if **I do not sign** this consent, Patterson Physical Therapy **may decline to provide treatment** to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Patient's Name (please print) Legal Guardian's Name (please print)

PATTERSON PHYSICAL THERAPY REGISTRATION FORM

Referral for physical therapy must be submitted at the time of the first appointment and must be written within the last 30 days. _____ (Initial)

I authorize Patterson Physical Therapy's licensed physical therapists and licensed physical therapist assistants to treat my medical condition by using physical therapy modalities and techniques as indicated by my evaluation. I authorize Patterson Physical Therapy to apply for benefits on my behalf, for services rendered by Patterson Physical Therapy, and I request payment for those services be made directly to Patterson Physical Therapy.

I certify that the insurance information I have provided to Patterson Physical Therapy is correct. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for services provided. I understand that I am personally responsible for paying all charges for services rendered to me and to make payment when due. _____ (Initial)

I give Patterson Physical Therapy permission to:

Speak with_____, and

leave messages on the answering machine, send emails. _____ (Initial)

At the discretion of Patterson Physical Therapy, missed or cancelled appointments without 24-hour notification will result in a $40.00 charge. _____ (Initial)

I understand that wearing a mask for Covid precautions is optional. I will follow the current CDC Covid guidelines if I am exposed to and/or have tested positive with Covid-19. _____(Initial)

In case of an emergency, I give permission to Patterson Physical therapy to contact:

_____ _____

(Name/Relationship) (Phone Number)

Patient Name (print): _____

Signature: _____ Date: _____