ProActive P.T.

Patient name: _____ Date of Birth: _____ /_____ /_____ Gender: ☐ Male ☐ Female
MM DD YYYY

Mailing address: _____ City: _____ State: _____ Zip: _____

Home ph. #: _____ Cell ph. #: _____ Email: _____

Employer: _____ Occupation: _____

Emergency Contact Name:_____ Relationship:_____ Phone:_____

Is this injury due to Workers' Compensation ☐ Yes* ☐ No

***If yes**: Claim #: _____ Insurance Co. name:_____ Date of injury:_____

Adjuster name:_____ Adjuster phone number:_____

Is this injury due to a motor vehicle accident ☐ Yes* ☐ No

***If yes**: Claim #: _____Insurance Co. name:_____ Date of injury:_____

State in which accident occurred:_____ Adjuster name:_____

Adjuster phone number:_____

Have you had any other physical therapy this year? ☐ Yes If Yes, how many visits:_____ ☐ No

Have you had any home health care this year? ☐ Yes If yes, D/C Date: _____ ☐ No

Primary Care physician: _____ Referring physician: _____

Chief complaint: _____ How long has this been a problem for you: _____

What is your goal for physical therapy ? _____

***Please rate your pain on a scale from 1-10 (Circle One) ***

☺ 1 2 3 4 5 6 7 8 9 10 ☹

No Pain Worst Pain

Please list any other doctors/specialists that you have seen for this problem: _____

Current medications: _____

_____

Are you sensitive to latex ? ☐ Yes ☐ No

Have you had any diagnostic testing for this problem? (X-ray, MRI, CT scan, other_____) ☐ Yes* ☐ No

*If yes, name of the facility where you had the testing done _____

Have you fallen in the last year? ☐ Yes* ☐ No

*If yes, how many times have you fallen _____ Did you sustain an injury? ☐ Yes ☐ No

OVER PLEASE

Please read and check all that apply, if none apply, please check "none apply"

- ☐ Changes in bowel/bladder function
- ☐ Constipation
- ☐ Cough
- ☐ Diarrhea
- ☐ Difficulty maintaining balance while walking
- ☐ Difficulty swallowing
- ☐ Dizziness/lightheadedness
- ☐ Fainting
- ☐ Falls
- ☐ Fatigue
- ☐ Fever/chills/sweats
- ☐ Headaches
- ☐ Heartburn/indigestion
- ☐ Muscle weakness
- ☐ Nausea/vomiting
- ☐ Numbness/tingling
- ☐ Shortness of breath
- ☐ Weight loss/gain
- ☐ **NONE APPLY**

Have you **EVER BEEN DIAGNOSED** with any of the following conditions?

(Check all that apply, if none apply, please check "none apply")

- ☐ Anemia
- ☐ Asthma
- ☐ Bladder/urinary tract infection
- ☐ Blood clots
- ☐ Bone or joint infection
- ☐ Cancer
- ☐ Chest pain/angina
- ☐ Circulation problems
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Eye problems/infection
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Kidney problems/infections
- ☐ Liver problems
- ☐ Lung problems
- ☐ Metal implant(s)
- ☐ Multiple sclerosis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Other arthritic condition(s)
- ☐ Pacemaker/defibrillator
- ☐ Pelvic inflammatory disease
- ☐ Rheumatoid arthritis
- ☐ Stroke/head injury
- ☐ Thyroid problems
- ☐ Ulcers
- ☐ **NONE APPLY**

Please list any additional diagnoses that are not listed above:

_____

_____

_____

_____

Please list any surgeries you have had (include dates):

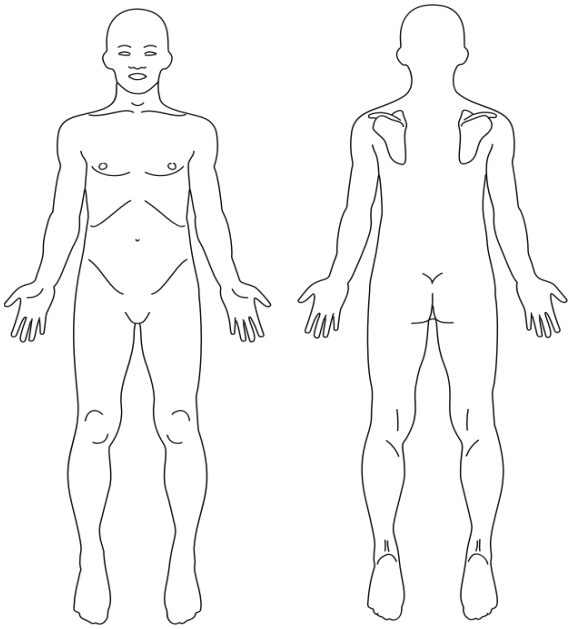
_____

_____

_____

_____

Body Chart:
Please mark the areas where you feel symptoms on the chart below



The above information I have provided is complete, true, and correct to the best of my knowledge

_____ _____

Patient/Guardian Signature – (if under 18, relationship to patient) **Date**

ProActive P.T.

Release of Information

List any individuals other than your referring physician that you authorize to receive information regarding diagnosis, treatment, and billing:

Name	Relationship

(IF PATIENT IS UNDER AGE 18)

Parent/guardian name:_____ Parent/guardian date of birth: ____ / _____ / _____

Consent to Treat

1. I have presented myself to this facility for therapy treatments and consent to the care (history, physical examination, treatment, etc.) that will be provided by my therapist.
2. I realize I have the right to refuse any treatments or procedures to the extent permitted by law. I acknowledge that the delivery of health care does not guarantee results of any treatments at this facility.
3. I understand that information from any medical record(s) kept by this facility may be used for education, administrative, and/or facility approved purposes when my personal identity will not be released.
4. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service. I am responsible for any services not covered by this authorization.
5. I authorize ProActive Physical Therapy to charge my debit, credit, or HSA card on file for any unpaid balance.
6. Workers' Compensation – I hereby authorize ProActive Physical Therapy to receive my records related to my work injury.

Notice of Privacy Practices

By signing this form, I acknowledge that ProActive Physical Therapy has made its' Privacy Notice available to me, which explains how my health information will be handled in various situations. I understand that I may discuss my concerns and/or any questions I have concerning this Privacy Notice with ProActive Physical Therapy representatives.

Authorization

I acknowledge, as indicated by my signature below, that I have read and fully understand this consent form. By signing this form, I am acknowledging my understanding of the "Notice of Privacy Practices" and authorizing persons listed on the "Release of Information" to receive my health information. **I understand that I will be changed a fee of $75.00 for any cancelled appointments without 24-hour prior notification or any missed appointments.**

_____ _____

Patient/Guardian Signature – (if under 18, relationship to patient) **Date**

OVER PLEASE