
(703) 444-8210

## PATIENT INFORMATION

**Full Name**: _____ **Email**: _____

**Address**: _____

**Phone**: _____ **DOB**: _____ **Age**: _____ **Gender**: _____

**Preferred Contact Method:** ☐ E-mail ☐ Phone ☐ Text Message

**Emergency Contact**: _____ **Phone**: _____

**Emergency Contact Relationship**: _____

**Employer**: _____ **Occupation**: _____

**Referred by**: _____

## INSURANCE INFORMATION

**Primary Insurance Company**: _____
Group #: _____ ID#: _____
Policyholder Name: _____ DOB: _____
Relationship to Patient: _____

**Secondary Insurance Company**: _____
Group #: _____ ID#: _____
Policyholder Name: _____ DOB: _____
Relationship to Patient: _____

## REFERRING PHYSICIAN

**Referring Physician**: _____ **Phone**: _____
Date of next visit with referring physician: _____

**Primary Care Physician**: _____ **Phone**: _____

## CURRENT CONDITION

**Height:** _____ **Weight:** _____

**Type of Injury/Condition:** _____
Date of Injury/Onset: _____

**Type of Surgery/Procedure:** _____
Date of Surgery: _____

**Please describe your physical limitations as a result of this injury/surgery:**

_____
_____

**Please describe any activities or movements that aggravate your symptoms:**

_____
_____

**Please describe any treatments, movements, or self-care that decrease your symptoms:**

_____
_____

**Please list any previous injury, conditions, or surgeries:**

_____
_____

**Have you had any of the following diagnostic tests in relation to this injury?**
☐ X-Ray ☐ MRI ☐ CT Scan ☐ Doppler ☐ Ultrasound ☐ Other: _____

**Which of the following describes your pain?** (check all that apply)
☐ Sharp ☐ Achy ☐ Burning ☐ Tingling ☐ Numbness ☐ Other: _____

**Are you currently taking any medications?** ☐ Yes ☐ No
Please list all medications and dosages: _____
_____

**Please rate your pain:** *(0=None, 5=Moderate, 10=Severe)*

At present: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
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

**Is your injury the result of a fall?** ☐ Yes ☐ No

**Have you fallen twice or more in the past year?** ☐ Yes ☐ No
Dates of falls: _____

## PATIENT MEDICAL HISTORY

**Have you been diagnosed with any of the following conditions?** (check all that apply)

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder/Bowel problems
- ☐ Cancer
- ☐ Cardiac disease/conditions
- ☐ Pacemaker/defibrillator
- ☐ Circulation problems
- ☐ Currently pregnant
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness/vertigo
- ☐ Emphysema/Bronchitis
- ☐ Fibromyalgia/Chronic fatigue
- ☐ Fractures
- ☐ Gastrointestinal problems
- ☐ Gallbladder/Kidney problems
- ☐ Headache/Migraines
- ☐ Hepatitis
- ☐ Hernia
- ☐ High blood pressure
- ☐ Incontinence
- ☐ Metal implants
- ☐ Multiple sclerosis
- ☐ Neurological disorder
- ☐ Numbness/tingling
- ☐ Osteoporosis/Osteopenia
- ☐ Pain syndrome/CRPS
- ☐ Parkinson's
- ☐ Seizures
- ☐ Speech problems
- ☐ Strokes
- ☐ Thyroid problems
- ☐ Vision problems

**Please describe in detail any diagnosis checked above:** _____

_____

_____

_____

**Have you suffered from any illness not listed here?** ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

## TREATMENT HISTORY & QUESTIONNAIRE

**Have you been treated for this condition before?** ☐ Yes ☐ No

If yes, by whom? _____ Was it helpful? ☐ Yes ☐ No

**What are your goals for Physical Therapy?** _____

_____

## CONSENT FOR CARE AND TREATMENT

I, the undersigned, hereby agree and give my consent Physical Restoration and Sports Medicine to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition. _____ (Patient initial)

FOR MINORS ONLY: CONSENT FOR CARE: As parent and/or legal guardian, I authorize the physical therapist named in this document to treat the minor patient named in the attached forms while I am not present. _____ (Parent/Guardian initial)

By signing below, I agree that all of the above information is correct, and that I authorize the physical therapist named in this document to provide me with therapy services and to furnish my physician, insurance company or attorney information concerning my injury and treatment.

**Payment** is due at time of service, we accept payment in the form of cash, check, Master Card, and Visa. We expect payment in full of any co-pays, deductibles, or co-insurances at time of service. We file your claims to your insurance company as a courtesy. You are responsible for suppling Physical Restoration and Sports Medicine with proper prescription, referrals, and authorization in order for your claims to be paid, if you do not supply us with proper documentation and your insurance denies your claims then you are responsible for paying your claim in full. Please check with your insurance company to verify benefits. You are also responsible to know how many visits you have been seen for with physical therapy. Most insurance companies have limitations. If you we are out of network with your insurance company then you are responsible for paying your entire visit in full at time of service.

We **do not** file Secondary Insurances unless you have Medicare as your Primary.

**Liability:** I agree that Physical Restoration and Sports Medicine is not responsible for loss of damage to personal belongings.

**Waiver and Release:** I hereby release, discharge and acquit Physical Restoration and Sports Medicine, its agents, representatives, affiliates, employees, or assigns, of and from any and all liability claims, demand, damage, cause of action, or loss of any kind airing out of or resulting form my refusal to accept, receive, or allow emergency and or medical services, including but not limited to ambulance services Emergency Medical Technician, Physician or Urgent Care services.

**No Show/Cancellation/Late Policy:** You must give a 24-hour notice if you plan to cancel your appointment. Failure to do so will result in a $50.00. If you no show for an appointment without cancelling you will automatically be charged $50.00.

**Authorization of Payment:** I hereby assign all benefits directly to and also authorize release of any medical record necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practice. I understand fully that in the event my insurance company or financially responsible party does not pay for the service I received; I will be financially responsible for payment.

**Notice of Privacy (HIPPA):** I acknowledge receipt of the Notice of Privacy Practice

## CLIENT SIGNATURE

Signature: _____ Date: _____

Print Name: _____