positiveenergy
Physical Therapy | Sports Performance

(ALL INFORMATION ON THIS FORM IS CONFIDENTIAL.)

CLIENT INFORMATION

Today's date: ______________

Name: ____ ☐ Male ☐ Female
First MI Last

Address: ____
Street Address City State Zip Code

Primary phone: ______-______-______ ☐ Cell ☐ Home ☐ Work Email address: ______________________

Date of birth: ______________________

Emergency contact: ______________________ Phone: ______-______-______ Relationship ______________

AUTHORIZATION FOR TREATMENT

I hereby consent to and authorize all therapy treatments, which in conjunction with the judgment of my attending physician, may be considered necessary and/or advisable for the diagnosis and/or treatment of the patient named above at Positive Energy.

Signature: ______________________________ Date: ______________________
(Parent or Legal Guardian must sign if client is under 18 years of age)

Relationship to client: ☐ Mother ☐ Father ☐ Legal Guardian

FINANCIAL POLICY AND INSURANCE INFORMATION:

Please check one box and sign.

☐ **FOR CLIENTS WHO WOULD LIKE TO USE THEIR HEALTH INSURANCE POLICY:**
I would like to use my health insurance and I agree that my insurance provider will be billed for services provided while attending physical therapy. I hereby give authorization for my insurance provider to pay Positive Energy directly. In the event my insurance company pays me directly, I will immediately deliver payment to Positive Energy. If my insurance provider does not pay for services, I am responsible and liable for payment to Positive Energy.

☐ **FOR CLIENTS WHO ARE NOT USING THEIR HEALTH INSURANCE POLICY:**
In lieu of using my health insurance, I will provide payment to Positive Energy.

Signature: ______________________________ Date: ______________________

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand the notice of privacy practices is available for me to review at www.positiveenergypt.com. Additionally, a copy of the notice will be provided upon request.

Signature: ______________________________ Date: ______________________

APPOINTMENT CANCELLATION AND NO-SHOW POLICY

Please provide us with at least 6 hours notice for cancellations or changes. Cancellations made less than 6 hours in advance will result in a $50 charge. A no-show will result in a $100 charge.

Signature: ______________________________ Date: ______________________

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Height: ________________ **Weight:** ________________

MEDICAL HISTORY: (Existing or relevant previous conditions.)

Condition			Condition			Condition		
Allergies	❑ Yes	❑ No	Dizzy Spells	❑ Yes	❑ No	MRSA	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Emphysema/Bronchitis	❑ Yes	❑ No	Multiple Sclerosis	❑ Yes	❑ No
Anxiety	❑ Yes	❑ No	Fibromyalgia	❑ Yes	❑ No	Muscular Disease	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Fractures	❑ Yes	❑ No	Osteoporosis	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Gallbladder Problems	❑ Yes	❑ No	Parkinson's	❑ Yes	❑ No
Autoimmune Disorder	❑ Yes	❑ No	Headaches	❑ Yes	❑ No	Rheumatoid Arthritis	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Hearing Impairment	❑ Yes	❑ No	Seizures	❑ Yes	❑ No
Cardiac Conditions	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No	Smoking	❑ Yes	❑ No
Cardiac Pacemaker	❑ Yes	❑ No	High Cholesterol	❑ Yes	❑ No	Speech Problems	❑ Yes	❑ No
Chemical Dependency	❑ Yes	❑ No	High/Low Blood Pressure	❑ Yes	❑ No	Strokes	❑ Yes	❑ No
Circulation Problems	❑ Yes	❑ No	HIV/AIDS	❑ Yes	❑ No	Thyroid Disease	❑ Yes	❑ No
Currently Pregnant	❑ Yes	❑ No	Incontinence	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Depression	❑ Yes	❑ No	Kidney problems	❑ Yes	❑ No	Vision Problems	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Metal Implants	❑ Yes	❑ No			

Describe any other conditions or precautions: ________________________________

____

____

____

____

Fall History

Injury as a result of a fall in the past year? ❑ Yes ❑ No Date of Fall: ________________

Two or more falls in the last year? ❑ Yes ❑ No Dates of Falls: ________________

Surgical History (If greater than three, please provide us with a list.)

Body Region:________________ Surgery Type: ________________ Date of Surgery: __________

Body Region:________________ Surgery Type: ________________ Date of Surgery: __________

Body Region:________________ Surgery Type: ________________ Date of Surgery: __________

Current Medications (If greater than three, please provide us with a list.)

Drug:________________ Dosage: ________ Reason for Taking:________________

Drug:________________ Dosage: ________ Reason for Taking:________________

Drug:________________ Dosage: ________ Reason for Taking:________________

❑ Currently not taking any medications.

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(ALL INFORMATION ON THIS FORM IS CONFIDENTIAL.)

1. Circle a value on the pain intensity scale that best describes your pain at its worst.
2. Shade the location of your pain on the body diagrams below.

PAIN INTENSITY **PAIN LOCATION**

10 Pain as bad as it could be

9 Excruciating

8

7 Severe

6

5 Moderate

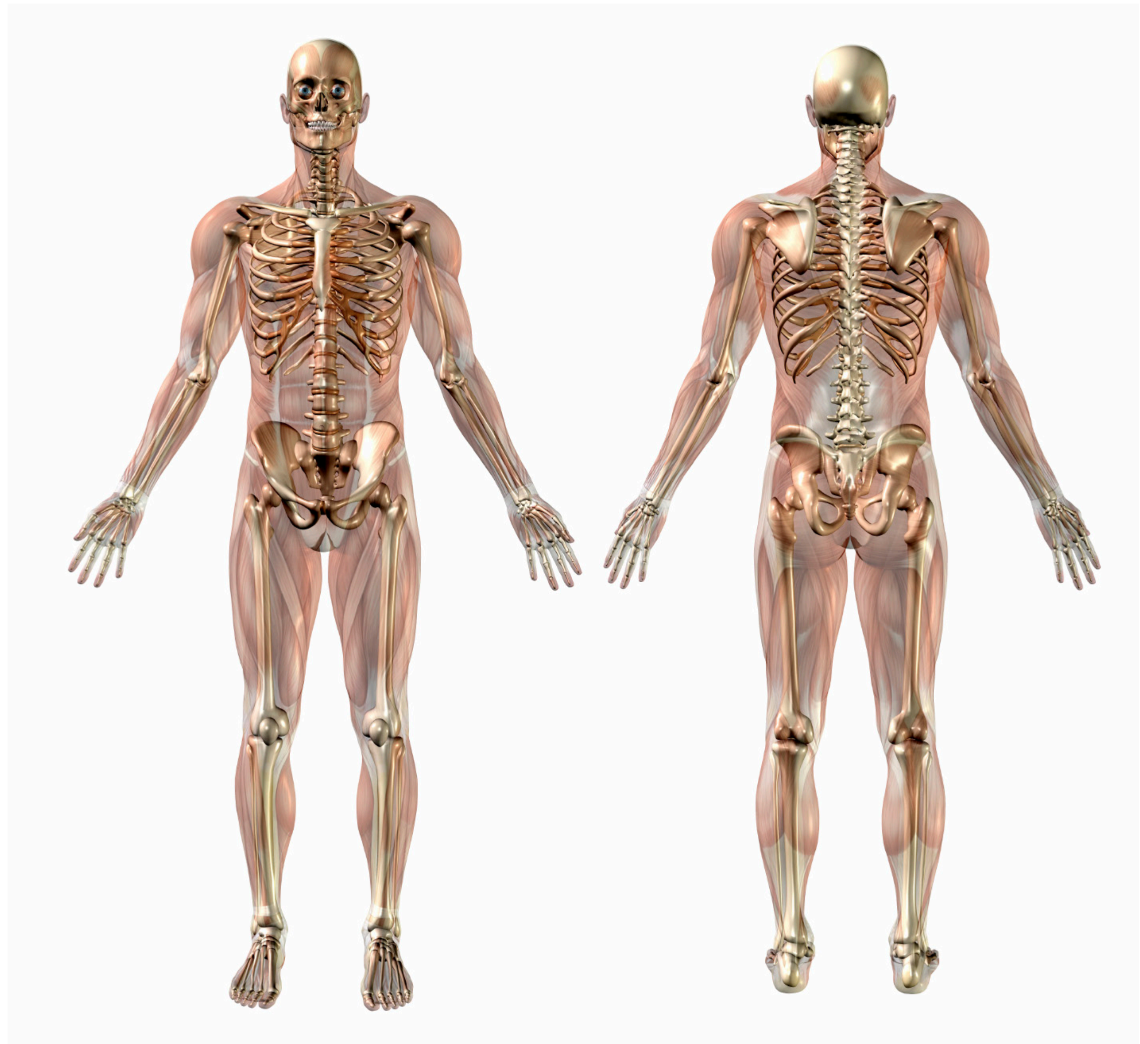
4

3 Mild

2 Slight

1

0 No Pain



Is there anything else you would like your physical thereapist to know? If so, please explain.

____

____

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