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)

## 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

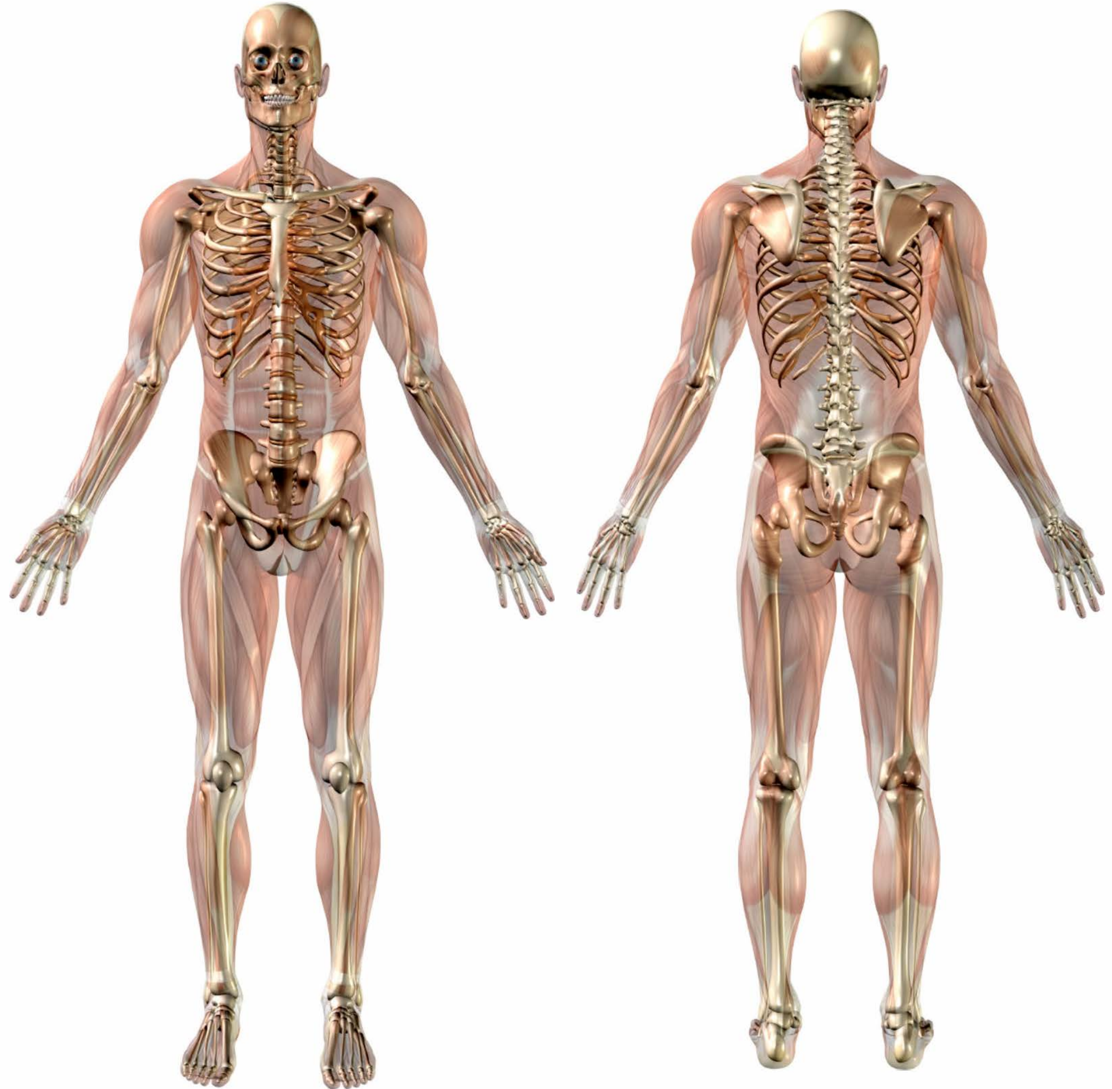
**4**

**3** Mild

**2** Slight

**1**

**0** No Pain



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

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________