

CLIENT INFORMATION

Today's date: _____

Name: _____
First MI Last

Male

Female

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: _____
(Parent or Legal Guardian must sign if client is under 18 years of age)

Date: _____

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 \$115 charge.

Signature: _____

Date: _____

Height: _____ **Weight:** _____

MEDICAL HISTORY: (Existing or relevant previous conditions.)

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

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.
