Centric Physical Therapy

Patient:____

Have you received any therapy services or chiropractic treatment this year? Yes No

Are you currently receiving ANY home health services? Yes No If yes, what is the name of the home health agency? ____________________________________ What is your discharge date? _______________

Primary chief complaint: ____________________ **Approximate start date:** ____________________

Which side of the body is affected? Please circle all that apply. Left Middle. Right

Have you been hospitalized in the past 3 months? Yes. No
If yes, please list the reason(s)____

List any previous treatments you have had for this injury/illness. Include hospitalizations, home health, injection, chiropractic or physical therapy.
____

Which symptom do you experience the most? Circle one. Dizziness Pain Numbness Weakness

Location: ____________________

Please rate your symptom from 0 meaning no symptoms to 10 meaning the worst symptoms possible.

At the worst: _________________ (0 to 10)

Current: _____________________ (0 to 10)

At best: _____________________ (0 to 10)

If you have pain, circle the words that describe your pain:
Burning Sharp Dull/Achy Throbbing Shooting Constant or Intermittent Worse in AM/PM

How would you describe your overall health? Good. Fair. Poor

Medical History. Please circle ALL known medical conditions and list any surgeries.

Alzheimer's
Immunosuppression
Heart Problems
Cerebral Vascular Accident (stoke)
Current Infection
Diabetes Mellitus Type I
Diabetes Mellitus Type II
Fibromyalgia
Fracture or Suspected Fracture
High Blood Pressure
History of Cancer
Lupus
Muscular Dystrophy
Obesity
Osteoarthritis
Parkinson's
Traumatic Brain Injury
Rheumatoid Arthritis
History of Falls. How many? _________
Other: ________________

List any diagnostic test or imaging that you have had, such as X rays, CT scans & MRIs. Include results if known.
____

What are your goals for physical therapy? ____

 Patient Name ____

Assignment Of Benefits - Consent For Treatment - Company Policies

_______ (**Initial Here**) **Assignment of Benefits:**
I authorize and request payment of medical benefits to Centric Physical Therapy for professional services rendered. I understand that I am financially responsible for charges not covered by this authorization.

_______ (**Initial Here**) **Consent For Treatment and Release of Information:**
I hereby consent to treatment for procedures which may be performed during this outpatient therapy at Centric Physical Therapy. I authorize the release of information concerning my diagnosis, evaluation, and treatment to my physician, insurance company, and case manager.

_______ (**Initial Here**) **Cancellation Policy:**
I understand that I will be charged a $25.00 fee if I fail to cancel my scheduled appointment 24 hour advanced notice. We allow a grace period of 2 cancellations without a full 24- hour notice.

_______ (**Initial Here**) **No Show Policy:**
I understand I will be charged a $25.00 fee if I “no show” for my scheduled appointment.

_______ (**Initial Here**) **Late Policy:**
I understand that if I am more than 15 minutes late, we may require you to rescheduled your scheduled appointment.

By signing below, I acknowledge that I have read and agree to all of the above listed company policies. I understand that these policies are subject to chance and may require review with additional signature acknowledgement.

Patient’s Signature: ________________________ **Date:** ________________________

Consent for Use & Disclosure of Protected Health Information

_______ **(Initial Here)** I have read Centric Physical Therapy’s Notice of Privacy Practices. I understand that by signing this consent, I am giving my consent to Centric Physical Therapy to use and disclose my protected health information to carry out treatment, payment activities and health care operations. I understand the terms of this notice may change with time and Centric Physical Therapy will always post the current notice at the clinic, on the website, and the clinic will have copies for distribution.

Indicated below are individuals whom Centric Physical Therapy may speak with regarding my treatment. I will notify Centric Physical Therapy in writing whenever this information changes.

____

Listed below are individuals whom I request restriction regarding my protected health information.

____

Do we have your permission to leave a confidential message at the phone number you provide?

_______ Yes _______ No

Patient Signature: ________________________ **Date:** ________________________