BodySensePT

PHYSICAL THERAPY FOR SPORT & LIFE

NAME: _____

DOB: _____

DATE: _____

For what reason are you coming to PT? _____

Date of Injury: _____ **Date of Surgery**: _____ **Type of Surgery**: _____

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

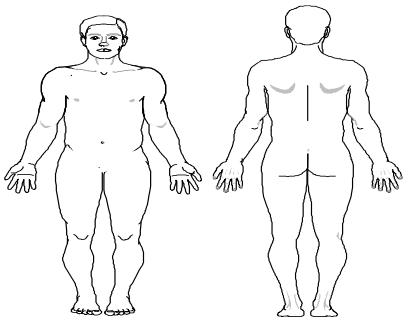
How did you hear about us? _____

Referring Physician: _____ **Primary Care Physician**: _____

Previous treatment for above problem (PT/chiro/injections/surgery/etc..) _____

_____

Shade the area of your problem:



Pain Rating *(over past 48 hrs):* (0=no pain and 10= worst pain imaginable)

Present: 0 1 2 3 4 5 6 7 8 9 10 *Least*: 0 1 2 3 4 5 6 7 8 9 10 *Worst*: 0 1 2 3 4 5 6 7 8 9 10

Numbness/Tingling/Loss of Sensation: Y/N Location: _____

Symptoms Aggravated by: _____

Symptoms Relieved by: _____

Does your pain affect your sleep: _____

Description of Symptoms (Circle): Sharp Dull Aching Burning Shooting Cramping Stabbing Numb Constant Intermittent Improving Getting Worse

Medical History:

Have you ever had any of the following?

__ Anemia
__ Arthritis: _____
__ Bleeding Disorders
__ Blood Clots
__ Cancer: _____
__ Circulation Problems
__ Congestive Heart Failure
__ Covid
__ Depression
__ Diabetes
__ Dizziness/Vertigo
__ Emphysema/COPD
__ Epilepsy/Seizures
__ Fibromyalgia
__ Gout
__ Hepatitis
__ Heart Attack
__ High Blood Pressure
__ HIV
__ Insomnia
__ Irregular Heart Beat
__ Kidney Problems
__ Lyme Disease
__ Migraines/Headaches
__ MRSA
__ Multiple Sclerosis
__ Osteoporosis/Osteopenia
__ Pacemaker
__ Pneumonia
__ Sleep Apnea
__ Stomach Ulcers
__ Stroke/TIA
__ Substance Dependency
__ Thyroid
__ Tuberculosis
__Other: _____
_____
_____
_____
_____

Please list any allergies: _____

Please list any surgeries you have had and the approximate dates in the past 10 years:

_____

_____

_____

Please list all medications/supplements (prescribed and over the counter) you are taking including dosage/frequency:

_____

_____

Please list your goals for Physical Therapy: _____

Please list anything that may limit your participation in Physical Therapy (transportation, work, school, finances, etc…):

_____

Leisure Activities/Hobbies: _____

Have you had more than 2 falls in the past 6 months? Y/N **Do you Live Alone**: Y/N **Do you have Stairs**: Y/N

Notice of Policies & Benefit Information:

I acknowledge that I have received information pertaining to both a) my specific insurance benefits/self pay arrangements/Financial Agreement and Assignment of Benefits and b) the cancellation/payment and HIPPA privacy policies of *BodySense PT, LLC.* I agree to abide by the responsibilities of the outlined documents.

Consent to Medical and Therapeutic Services:

I consent to all procedures which may be performed during the duration of the outpatient treatment, including emergency treatment. I understand that if I fail to carry out follow – up medical care, I do so at my own risk.

I also understand that the rehabilitation process, by its very nature, involves certain inherent and unavoidable risks - including falls and other similar injuries, and that the only alternative to the entirely avoiding these risks would be to forego rehabilitation altogether. I accept these risks, realizing that all reasonable attempts are made to minimize them.

I acknowledge that *BodySensePT* takes measures to limit the spread of infectious illnesses. If I develop symptoms of potential cold/flu/strep/COVID/other (e.g. runny nose, cough, fever, sneezing, sore throat, shortness of breath, etc) I will contact the office to reschedule or discuss alternative arrangements. I also acknowledge that *BodySensePT* has a proper sanitation and disinfection plan in place and is not responsible for any accidental transmission of cold/flu/strep/COVID/other illness that could occur by being in their business or within close proximity of one another.

I consent to the use or disclosure of my protected health information by *BodySense PT, LLC* for the purpose of providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations on behalf of *BodySense PT, LLC.* I understand that my treatment is conditioned upon my consent as evidenced by my signature below. In the event a parent does not accompany a minor to the appointment, I consent to allow treatment to be performed.

I agree to allow *BodySense PT* to send texts/emails to my phone/email address. *Yes____ No____ Initial _____*

_____

Patient/Legal Guardian Signature **Date**

_____

Staff Signature **Date**