Longview Physical & Sports Therapy Services, PS

Name: _____

Health Care Provider: _____

Are you: a. ☐ Right-handed b. ☐ Left-handed

With whom do you live:

☐ Alone
☐ Spouse only
☐ Spouse and other(s)
☐ Child (not spouse)
☐ Parent
☐ Other relative(s) (not spouse or children)
☐ Group setting
☐ Other:

Employment/Work

Occupation: _____

Living Environment

Do you use:
☐ Cane/crutches
☐ Walker
☐ Manual wheelchair
☐ Motorized wheelchair

General Health Status

Please rate your health:
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Social/Health Habits

Currently smoke tobacco ☐ Yes ☐ No
Exercise:
Do you exercise beyond normal daily activities and chores?
☐ Yes Describe the exercise: _____
On average, how many days per week do you exercise? _____
☐ No

Current Condition(s)/Chief Complaint(s)

Describe the problem(s) for which you seek physical therapy: _____

_____

_____

When did the problem(s) begin (date)?

Month	Day	Year
☐☐	☐☐	☐☐☐☐

What happened? _____

_____

Have you ever had the problem(s) before?
☐ Yes
What did you do for the problem(s)? _____

_____

Did the problem(s) get better? ☐ Yes ☐ No

Patient/Guardian Signature: _____

Medical/Surgical History

Please check if you ever had:

☐ Arthritis	☐ Multiple sclerosis
☐ Broken bones	☐ Muscular dystrophy
☐ Osteoporosis	☐ Parkinson disease
☐ Blood disorders	☐ Seizures/epilepsy
☐ Circulation/vascular	☐ Development or growth problems
☐ Heart problems	
☐ High blood pressure	☐ Thyroid problems
☐ Lung problems	☐ Cancer
☐ Stroke	☐ Infectious disease (eg. tuberculosis, hepatitis)
☐ Diabetes/high blood sugar	☐ Kidney problems
☐ Low blood sugar/ Hypoglycemia	☐ Repeated infections
	☐ Ulcers/stomach problems
☐ Pacemaker	
☐ Depression	☐ Skin diseases

☐ **Surgeries:** _____

Within the past year, have you had any of the following symptoms? (Check all that apply)

☐ Chest pain	☐ Difficulty sleeping # of hrs of sleep ____
☐ Heart palpitations	
☐ Loss of appetite	☐ Nausea/vomiting
☐ Shortness of breath	☐ Bowel problems
☐ Dizziness or blackouts	☐ Weight loss/gain
☐ Coordination problems	☐ Weakness arms or legs
☐ Urinary problems	☐ Headaches
☐ Loss of balance	☐ Hearing problems
☐ Difficulty walking	☐ Vision problems
☐ Joint pain or swelling	☐ Pain at night
☐ Falls	

Medications

Do you take any prescription medications?
☐ Yes ☐ No
If yes please list medications:

_____

_____

_____

Prednisone in the last year ☐ Yes ☐ No
Coumadin or other blood thinner ☐ Yes ☐ No

For women only: Pregnant or might be pregnant?
☐ Yes ☐ No

Other Clinic Tests Within the past year, have you had any of the following tests? (Check all that apply)

☐ Angiogram	☐ Arthroscopy
☐ MRI	☐ Bone scan
☐ NVC (nerve conduction)	☐ CT scan
☐ Stress test (treadmill)	☐ Other: _____
☐ X-rays	

Have you been in a SKILLED NURSING FACILITY or received HOME HEALTH CARE in the past 30 days?
☐ **Yes** ☐ **No**

Are you aware of your diagnosis & prognosis as explained by your health provider? ☐ Yes ☐ No

Date: _____

Longview
Physical & Sports Therapy
Services, PS

Patient Name: _____

Consent for Treatment

I do hereby agree and give my consent for Longview Physical & Sports Therapy Services, P.S. to furnish medical care and treatment considered necessary and proper.

Release of Information

I authorize Longview Physical & Sports Therapy Services, P.S. to release all information necessary, including medical records, to secure payment.

I authorize Longview Physical & Sports Therapy Services, P.S. to obtain medical records from my physician or other medical professional as it relates to my treatment.

Assignment of Benefits

I authorize payment directly to Longview Physical & Sports Therapy Services, P.S. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment is to be considered as valid as the original.

Payment Guarantee

I agree to pay Longview Physical & Sports Therapy Services, P.S. for the services provided to me or the party named above. If the law (Workers Compensation) or my payor contracts prohibits my payment for these services I will cooperate and/or assist in the provision of information, releases, etc. to allow for speedy collection for my third party payor. Where the law or payor contract does not prohibit payment by me, I acknowledge responsibility for any/all account balances.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my physical therapy treatments.

I have read and agree to all the terms as stated above. I understand my responsibility for the payment of my account.

_____ _____

Signature of Patient/Guardian/Responsible party Date

Longview
Physical & Sports Therapy
Services, PS

Attendance Policy

Arrive on Time

It is important to arrive on time to your scheduled appointment. If you arrive more than 10 minutes late, your therapist will try to fit your treatment in, depending on availability of open time slots.

Cancellation & No Show

If you must cancel your visit, **please give at least 24 hour** notice so we can fill your time with another patient waiting to be seen. We will consider **less than 3 hour** notice as a no show. We will contact you after up to **2 no show** appointments, and will be glad to reschedule your appointment. If we do not hear from you, we will assume you do not intend to continue therapy and will erase all future appointments.

You are the most important part of your rehabilitation! Your success depends on how actively you participate in your therapy program.

Patient/Guardian: _____ **Date:** _____

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