Welcome!

Thank you for selecting Advanced Physical Therapy & Rehabilitation Center as your choice for physical therapy! We pride ourselves in helping our patients receive the utmost care to get back to their everyday living! Please complete this medical form to assist you the best way possible! Thank you!

Patient #_____
SS#_____

Patient Information (CONFIDENTIAL) Date _____

Name _____Birthdate _____Phone_____
Cell Phone_____ Work Phone_____
Address_____City_____State_____Zip Code_____
Patient Sex: □ Male □ Female Marital Status: □ Minor □ Single □ Married □ Divorced □ Widowed
Spouse or Parent/Guardian's Name_____ Phone _____
Person to contact in case of emergency _____Phone_____
How were you referred here?_____

Patient Medical History

What measures do you take to relieve pain? □ Drugs/Alcohol □ TENS Unit □ Elevation □ Heat/Cold
□ Rest/Relaxation □ Other _____
Have you had any previous physical therapy treatment this year? □ Yes □ No
Where _____When _____
Response _____How many visits _____

Current Medication

Name of Medication:
_____ _____
_____ _____
_____ _____

Has Alcohol intake/cigarette increased since injury? □ Yes □ No
When was your last physical exam? _____ Was it Normal? _____
When was your last stress test? _____ Was it Normal? _____
In the past 12 months, have you had any increased anxiety? If yes, what was the source? _____
_____

Surgical History_____
_____
_____

Past History

Have you ever had
□ Yes □ No Heart condition/pacemaker
□ Yes □ No Varicose veins or phlebitis/blood clots
□ Yes □ No Arthritis
□ Yes □ No Diabetes/hypoglycemia
□ Yes □ No Epilepsy or seizures
□ Yes □ No Eye problems □ Corrective lenses □ Other _____
□ Yes □ No Depression
□ Yes □ No High blood pressure
□ Yes □ No Recurrent headaches/migraines
□ Yes □ No Skin problems
□ Yes □ No Lung disease
□ Yes □ No Uncontrolled Bladder or incontinence
□ Yes □ No Allergies to any drugs (Name _____)

Need Related Services?

As a result of this injury:

Are you experiencing any problems with transportation to physical therapy?

□ Yes □ No

Are your experiencing any other difficulties?

□ Yes □ No If yes, explain _____

_____

_____

Exercise History

Are you currently involved in a program of regular activity? □ Yes □ No
1) _____ 2) _____ 3) _____

Present History

Please explain the nature of your injury: _____
_____
_____
_____
_____
_____
_____
_____

Symptoms Related to Injury – IF APPLICABLE

Best time of day: □ Morning □ Afternoon □ Evening
Worst time of day: □ Morning □ Afternoon □ Evening
Maximum time sitting: _____ Minutes / Hours
Maximum time standing: _____ Minutes / Hours

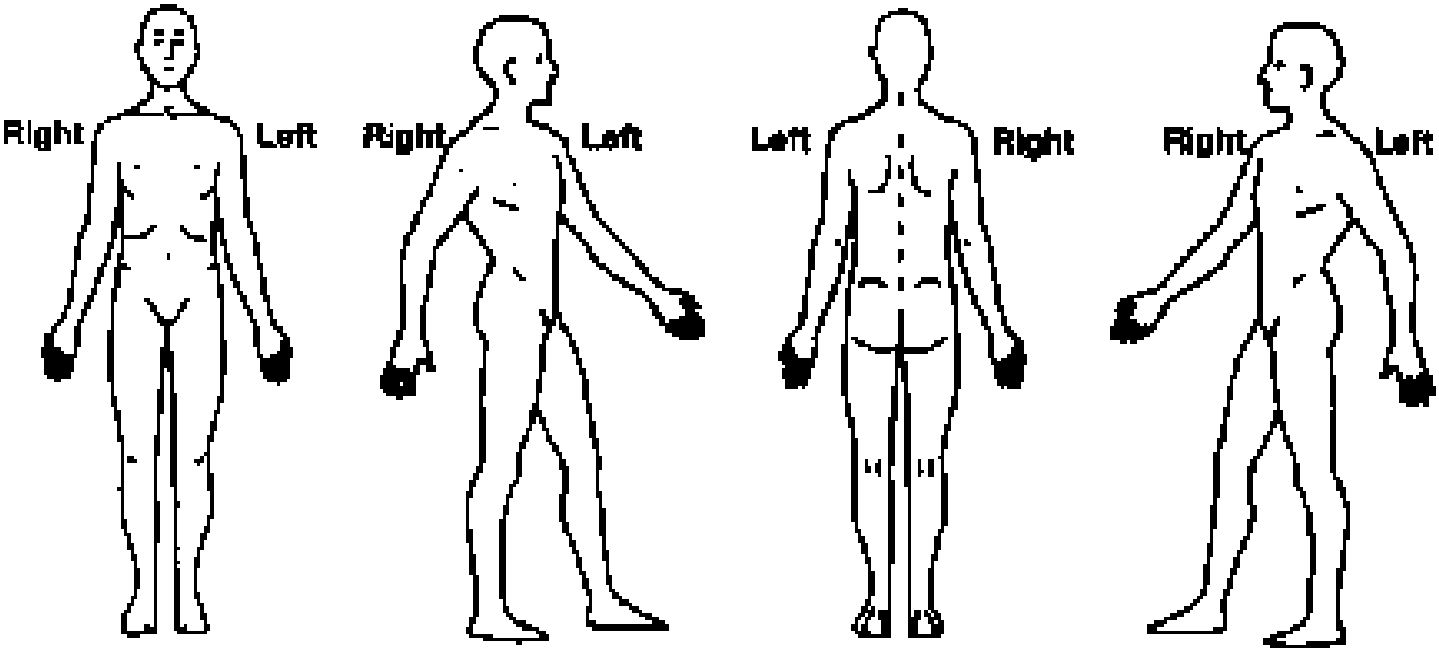
Height _____ Weight _____ Occupation _____

Pain Level – (1) LEAST PAIN (5) MODERATE PAIN (10) SEVERE PAIN

In the **past 30 days**, rate your pain 0 – 10 at:

Best _____/10 Worst _____/10 Present _____/10

Shade in areas of Pain, Numbness, and Tingling



Admission Consent

AUTHORIZATION FOR TREATMENT

I hereby authorize Advanced Physical Therapy & Rehabilitation Center to render treatments as prescribed by my physician, Dr. _____

X _____ _____
Signature of patient (parent/guardian if minor) Date

SOCIAL / VOCATIONAL SERVICES

I understand that Social Work and Vocation services/counseling are available through Advanced Physical Therapy & Rehabilitation Center.

- I would like further information regarding these services □ Yes □ No

X _____ _____
Signature of patient (parent/guardian if minor) Date

AUTHORIZATION OF PAYMENT

I hereby:

- Assign to Advanced Physical Therapy & Rehab Center all insurance benefits applicable for the payment of services.
- Know and agree that I am responsible for all insurance *co-pays, deductibles, non-covered services, and amounts not paid by my insurer.*

X _____ _____
Signature of patient (parent/guardian if minor) Date

*****AQAUTIC ADMISSIONS CRITERIA*** – *IF APPLICABLE***

In order to be eligible to receive Aquatic Therapy in the therapeutic pool at Advanced Physical Therapy & Rehabilitation Center, the patient cannot have any of the following.

1) Uncontrolled bladder or bladder incontinence	□ **Yes**	□ **No**
2) Colostomy bag	□ Yes	□ No
3) Catheter of any type	□ **Yes**	□ **No**
4) Infectious disease	□ Yes	□ No
5) Open wounds	□ **Yes**	□ **No**
6) Contagious skin rash (draining boils)	□ Yes	□ No
7) Cardiac failure	□ **Yes**	□ **No**
8) Urinary infections	□ Yes	□ No
9) Vomiting	□ **Yes**	□ **No**
10) Scabies or lice	□ Yes	□ No
11) Uncontrolled seizures	□ **Yes**	□ **No**
12) Excessive fear of water	□ Yes	□ No
13) Cognitive or functional impairment that creates A hazard to the patient or to others in the pool	□ **Yes**	□ **No**
14) Severely weakened or deconditioned state that poses a safety hazard	□ Yes	□ No
15) Extremely poor endurance	□ **Yes**	□ **No**
16) Severely decreased range of motion that limits Function and poses a safety hazard	□ Yes	□ No

X _____ _____
Signature of patient (parent/guardian if minor) Date

CANCELLATION NOTICE

In order to provide excellent service to all of our patients, we appreciate a notice if you are unable to attend your scheduled appointment!

INSURANCE NOTICE

Due to the constant changing insurance policies, it can be difficult to interpret each individual's insurance policy.

However, we do try to stay on top of these changes. In order to continue to do so, you need to provide your insurance information and any insurance changes.

IT IS YOUR RESPONSIBILITY TO BE KNOWLEDGABLE ABOUT YOUR INDIVIDUAL INSURANCE COVERAGE

It is important to understand that ALL insurance policies have exclusions, such as non-covered services and amounts exceeding insured limits, and please beware if you have a ***deductible*** and/or ***co-payments.***

Signature: _____Date:_____