PATIENT INFORMATION

(Please complete both sides of form)

Date_____ Clinic Location _____

Name_____
(First) (Last) (Middle)

Height _____ Weight _____

Address_____Apt#_____

City_____ State_____ Zip_____

Cell Phone_____ Home Phone_____

Birth Date_____ Social Security No. _____

Email_____

Marital Status: o Married o Single o Other Sex: o M o F

How did you hear of React Physical Therapy?

o I am a former patient
o Friend/Relative, Name: _____
o Social Media
o Magazine or Online Article _____
o Google/Internet Search
o React Physical Therapy Staff, Name: _____
o Doctor who wrote my prescription
o Other _____

PHYSICIAN INFORMATION

Referring Physician _____ Phone_____

Address _____ Fax _____

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PHYSICAL THERAPY

PATIENT HEALTH & MEDICAL HISTORY

Exercise Frequency: _____ Exercise Type(s): _____

Do you smoke? _____ How often? _____

Are you pregnant? _____ If yes, # of weeks: _____

Do you have a pacemaker? _____ Allergies: _____

Medications:

List all of the Prescription Medications or Over the Counter Drugs you are now taking (We can copy a detailed list if you have one):

Complaint:

What is your major complaint? _____

Start Date: _____ Possible Cause: _____

Symptoms: _____

Previous doctors seen for complaint: _____

Previous treatment for complaint: _____ How recent? _____

Symptom-Aggravating Factors: _____

Symptom-Relieving Factors: _____

Time of Day Symptoms are Best: _____ Time they are Worst: _____

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PATIENT HEALTH & MEDICAL HISTORY

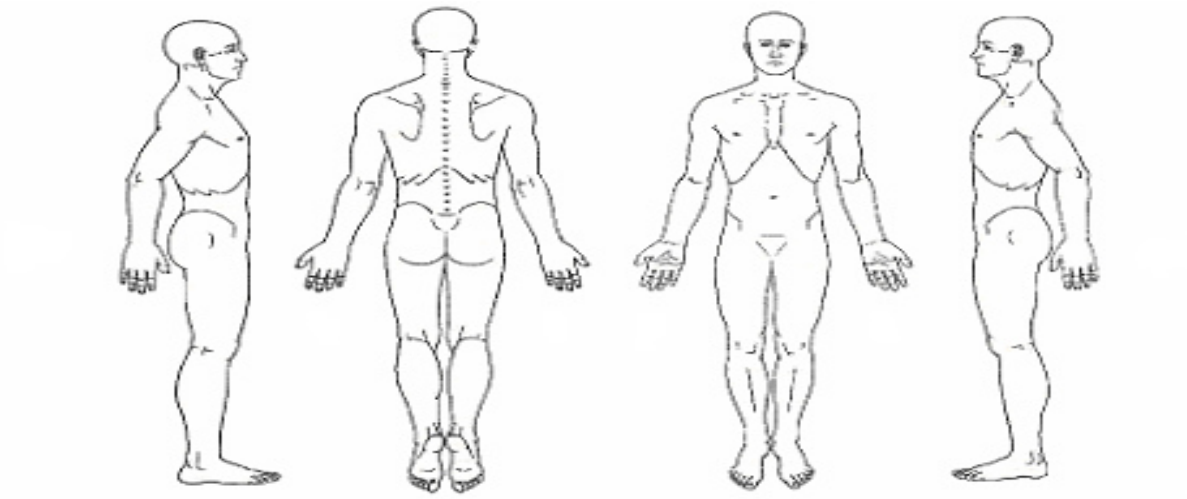
Current duration of Pain: o Intermittent o Constant o With Certain Motions

Is your pain getting better or worse? _____ Have you had this injury before? _____

Type of Pain/Symptom (check all that apply):

o Dull o Numbness o Throbbing o Shooting o Sharp o Achy o Tingling o Burning

CIRCLE AREAS OF PAIN BELOW



How would you rate your pain **right now**? 0=no pain and 10=worst possible pain

0 1 2 3 4 5 6 7 8 9 10

How would you rate your pain **at it's best**? 0=no pain and 10=worst possible pain

0 1 2 3 4 5 6 7 8 9 10

How would you rate your pain **at it's worst**? 0=no pain and 10=worst possible pain

0 1 2 3 4 5 6 7 8 9 10

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PATIENT HEALTH & MEDICAL HISTORY

Have you **recently** noted any of the following? (check all that apply)

o Changes in bowel or bladder function
o Headaches
o Weight loss/gain
o Dizziness/lightheadedness
o Numbness/tingling
o Shortness of breath
o Difficulty maintaining balance while walking
o Fever/chills/sweats
o Nausea/vomiting
o Pain at night
o Weakness/fatigue
o Difficulty swallowing
o Changes in appetite

Do you have any of the following **today**? (Check all that apply)

o AIDS/HIV
o Anemia
o Angina
o Arteriosclerosis
o Arthritis
o Asthma
o Blood Clots
o Cancer
o Chemical Dependency
o Circulation Problems
o Depression
o Diabetes
o Epilepsy
o Heart Problems
o Osteoporosis
o Heart Problems
o Hemophilia
o High/Low Blood Pressure
o Joint/Bone Infection
o Liver Problems
o Lung Issues
o Multiple Sclerosis
o Musculoskeletal Problems
o Pneumonia
o Stroke
o STD
o Tuberculosis
o Urinary Infection

Have you...	Yes	No	If yes, explain briefly
...been hospitalized in the last 5 years?	o	o	_____
...had any mental disorders?	o	o	_____
...had any broken bones?	o	o	_____
...had any strains or sprains?	o	o	_____
...ever used orthotics?	o	o	_____

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PATIENT HEALTH & MEDICAL HISTORY

Do you take minerals, herbs, or vitamins? If yes, please list _____

How is most of your day spent? o Standing o Sitting o Other: _____

When was your last physical exam? _____

Please list past surgical history with approximate dates:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

Please list any serious medical conditions for which you have been treated/hospitalized in the past:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

During the past month, have you felt down, depressed, or hopeless? o Yes o No

During the past month, have you been bothered by having little interest or pleasure in doing things? □ Yes □ No

Is this something with which you would like help? (Circle) YES
YES, BUT NOT TODAY
NO

Do you have any other health issues or concerns that our staff should be made aware of?

What are your goals for Physical Therapy?

The above information I have supplied is complete, true, and correct to the best of my knowledge.

Signature of Patient or Legally Responsible Person _____

Date _____ Printed Name of above _____

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PHYSICAL THERAPY

INSURANCE VERIFICATION
(Completed by React Physical Therapy Employee and Reviewed at Initial Examination)

Copy of Insurance Card and ID:

	In Network	Out of Network
Coverage		
Deductible/Amount Met		
Visit Limit		
Co-Pay		
Out of Pocket		

Representative Name _____

Case Number_____

Date Verified _____ Verified By _____

Documentation Required? Yes o No o

Pre-certification Required? Yes o No o

Signature of Patient or Legally Responsible Person _____

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CONSENT AND STATEMENT OF FINANCIAL RESPONSIBILITY

1. CONSENT FOR TREATMENT: I consent to and authorize my physical therapist, occupational therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment.

2. APPOINTMENT ATTENDANCE AGREEMENT: I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times given one week do not automatically follow through to subsequent weeks. I agree to provide at least 24 hours notice when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel/no show charge of $30 or $50 depending on appointment type. WORKER'S COMPENSATION PATIENTS: We appreciate your full cooperation in attending all scheduled therapy sessions.

3. RESPONSIBILITY FOR PAYMENT: All co-payments are due at the time of service. I acknowledge that in consideration of the services provided to me by React Physical Therapy, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide React Physical Therapy with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible. Please note that refusal to sign this form does not change responsibility for payment in any way.

4. ASSIGNMENT OF BENEFITS: I hereby assign to React Physical Therapy all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

5. ACCESS TO AND RELEASE OF HEALTH INFORMATION: I understand that React Physical Therapy may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and React Physical Therapy's administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received React Physical Therapy's Notice of Privacy Practices and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.

6. CONSENT FOR EMERGENCY CONTACT INFORMATION: Person to contact in case of an emergency:

Name/Relationship _____ Telephone Number _____

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

Signature of Patient or Legally Responsible Person _____

Date _____ Printed Name of above _____

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PHYSICAL THERAPY