PROVIDENT
PHYSICAL THERAPY
& REHABILITATION
Exceptional Care, Outstanding Results

Name: _____
Last First Middle

Birthdate: ____/____/____ **Age:** _____ **Sex** ☐F ☐M

Address:
_____
_____

Appointment Reminders:

☐ Email **E-mail address:** _____

☐ Text Message **Cell Phone #:** _____

Provider: ☐ Verizon ☐ AT&T ☐ Sprint ☐ T-Mobile ☐ Other_____

How did you hear about this clinic?

Reason for PHYSICAL THERAPY? (include body part and indicate right or left)

Describe briefly your present symptoms:

Have you ever had a similar problem? ☐ Yes ☐ No **How long ago?** _____

Pain Scale (0-10 level) With 0 being the lowest and 10 the highest: _____

Date that Injury Began? _____

Has the problem been ☐ Chronic (6weks or more ☐ Subacute(2-6 week ☐ Acute (less than 2 weeks)

What makes symptoms better? _____

What makes symptoms worse? _____

X-RAY or MRI ☐ Yes ☐ No **Date of Exam:** _____

Where performed? _____ **Phone number:** _____

For this injury, did you have surgery? ☐ Yes ☐ *No* **Date of surgery:** _____

Hospital/ Surgical Site Name: _____

Would say your health is ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Exercise Habits: _____

Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No

What is it TODAY that you can't do in your daily activities that you used to do?

1. _____

2. _____

3. _____

4. _____

5. _____

Drug allergies: ☐ No ☐ Yes If yes, to what? _____

Medications: Please list all medications that you currently take. Include non-prescription medications & vitamins/ supplements **OR** provide medication list if available

Name of drug	dosage and frequency

MEDICAL HISTORY

Have you ever had any of the following listed below?

- ☐ NONE
- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypothyroidism
- ☐ Goiter
- ☐ Cancer (type) _____
- ☐ Leukemia
- ☐ Psoriasis
- ☐ Angina
- ☐ Heart problems
- ☐ Heart murmur
- ☐ Pneumonia
- ☐ Pulmonary embolism
- ☐ Asthma
- ☐ Emphysema
- ☐ Stroke
- ☐ Epilepsy (seizures)
- ☐ Cataracts
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Crohn's disease
- ☐ Colitis
- ☐ Anemia
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Stomach/peptic ulcer
- ☐ Rheumatic fever
- ☐ Tuberculosis
- ☐ HIV/AIDS
- ☐ Other_____

ADDITIONAL INFORMATION

Referring Doctor: _____

Address: _____

Phone Number: _____

Primary Care Doctor: _____

Address: _____

Phone Number: _____

Emergency Contact: _____

Phone Number: _____

Relationship: _____

For Medicare Patients only:

Have you been seen by OR are you currently being seen by a Home Health Care Agency? ☐ Yes ☐ No

If yes, when? _____

Patient Signature: _____ Date: _____

Informed Consent for Physical Therapy

Dear Patient:

Physical therapy involves the use of many different types of physical evaluation and treatment. At *Provident Physical Therapy* we use a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks with physical therapy.

Since the physical response to a specific treatment can vary wide from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment may be. You have the right to decline any portion of your treatment at any time before or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercise, your therapist will be glad to answer them.

I acknowledge that my treatment program has been explained by a therapist at Provident Physical Therapy, and all of my questions have been answered to my satisfaction, I understand the risks associated with a program of Physical Therapy as outlined to me, and I wish to proceed.

Date	Patient Name	Patient Signature

If Patient listed is a Minor:

_____
Parent/ Legal Guardian/ Representative Name

_____
Parent/ Legal Guardian/ Representative Signature

_____
Relationship to Patient

Authorization for use of Signature on File for Claim Authorization

_____ _____

Insurance Plan(s) Patient's Name

I, _____ authorize Provident Physical Therapy & Rehab/ Provident Physical and Occupational Therapy to mark the section "Enrollee or Authorization Person's Signature" with the notation "Signature on file".

This section authorizes:

1. The release of any medical information necessary to process this claim.
2. Payment of medical benefits to the undersigned physicians or supplier of services.
3. This authorization will remain in force until terminated in writing by the enrollee.

_____ _____

Patient's Signature Date

_____ _____

Parent / Guardian Signature Relationship to patient

- If the patient is unable to sign, a representative's signature is required; indication of the relationship to the patient as well as reason unable to sign. If the patient is under the age of 18, a parent or guardian must sign.
- If the patient does not have a representative present, verbal consent may be obtained and the medical personnel obtaining the consent may sign.