Drumhill Physical & Sports Therapy, 10 Jean Avenue Suite 10 Chelmsford, MA 01824

Name: _____ Date of Birth: _____ Age_____

Address: _____ Home Phone ( ) _____-_____
(Number & street)

_____ Cell Phone: ( ) _____-_____
(City or town) (State) (Zip code)

Email: _____

Can a member of our staff leave a message on: **Home phone** (Y) or (N) **Cell phone**(Y) or (N) **Email**(Y) or (N) if needed?

In case of emergency, who should we contact?

_____Relationship_____Phone (_____) _____

Insurance Information:

Primary Insurance Company: _____ID#:_____

Subscriber: _____ Subscriber D.O.B._____ Relationship to subscriber: _____

Secondary Insurance Company: Please list any secondary insurance here. This would include Medicare supplement plans and your private insurance if a worker's compensation or auto carrier is primary.

Secondary Insurance Company: _____ ID#_____

Subscriber: _____ Subscriber D.O.B._____ Relationship to subscriber: _____

Have you been treated for PT anywhere in the last 12 months? ☐ Yes ☐ No Where: _____

If **Medicare**, are you receiving or have you recently received **ANY** home services (including a nurse, home health aide)
Yes____ No_____ Date of discharge: _____

Check if worker comp or auto accident: W/C claim? _____ Auto accident? _____ Date of Injury: _____

INSURANCE & PAYMENT POLICY

Patient payments vary with insurance plans. Most plans have either a deductible, copay or co-insurance amount for each visit. Some insurance plans require pre-authorization or insurance referral. Please check with your insurance company if you are unsure. Should your insurance company deny payments, you will be responsible for payment of charges.

I authorize release of my medical records to my insurance company if necessary, to process my claim. I understand I am responsible for any payment of charges that is not paid by insurance. I understand that I am responsible for obtaining an insurance referral if needed by my insurance company. If anything is to change with my insurance I understand I have to notify the billing staff when changes occur.

Patient/Guardian Signature: _____ Date: _____

*PLEASE FILL OUT THE BACKSIDE OF THIS FORM & SIGN

TREATMENT CONSENT, PATIENT PRIVACY & MEDICAL INFORMATION POLICIES

Physical Therapy (PT) patient care services provided in response to medical care needs of outpatients of all ages regardless of gender, color, race, creed, national origin or disability. The purpose of PT is treat disease, injury, and disability, by evaluation, examination, testing, and use of rehabilitation procedures, manipulations, massage, exercise, and physical agents including, but not limited to, mechanical devices, heat, cold, light, water, electricity, and sound in the aid of establishing a PT functional diagnosis and treatment program; obtain information needed in evaluation of patients to prevent/minimize residual physical therapy. PT can aid patient in achieving maximum potential with capabilities, and accelerate convalescence and reduce length of functional recovery. PT practice includes, but is not limited to, patient education, electrical stimulation, iontophoresis, and application of topical medications, splinting, and biofeedback services. You are not expected to experience an increase in your current pain level/discomfort. You should attempt to stop each procedure before you experience any increase in your current pain level and discuss with your therapist. You may be asked to partially disrobe, in which case a hospital gown will be provided. If this is necessary, your privacy will be always considered. Should you feel uncomfortable, you may refuse, stop the procedure, and/or request another therapist. There are certain inherent risks with PT treatments as you will be asked to perform activities and exert effort with increasing degrees of difficulty which could cause an increase in current level of pain/discomfort. There is a possibility to experience a new injury, but this risk is small, and you can control this by stopping if you feel any increase in symptoms, or sense of new symptoms developing. Your therapist will take precaution to ensure you are protected from a hazardous situation. You will never be forced to perform any procedure and/or comply with treatment that you do not wish to perform and/or have performed on to you.

Based on the above information, I agree to cooperate fully and to participate in all PT procedures. I give my consent to be evaluated and treated in PT. I acknowledge that I have read and received a copy of the Authorization for treatment letter. I authorize release of medical information to appropriate third parties. I have seen the notice of information of practice regarding patient privacy laws and provisions posted by the front desk.

Patient/Guardian Signature: _____ Date: _____/_____/_____

CANCELLATION & NO-SHOW APPOINTMENT POLICY

Therapy Attendance Policy: Our office requires a 24-hour notice for appointment cancellations. At Tewksbury Physical Therapy, we want you to get the most out of your PT visits. Attending all your scheduled treatment sessions can significantly increase your success. We encourage you to develop a workable schedule with your therapist.

A $75 missed visit fee will be charged on your second No-Show or cancellation given within less than 24-hour notice.
This amount is your responsibility; insurance companies will not cover a missed visit fee.

Your 1st No-Show or late cancellation: You will receive a phone call informing you that you missed the scheduled appointment. As a courtesy, we will waive the fee for the first occurrence.

Repeated No-Shows/late cancellations: You will be required to call-in for same day scheduling or possibly be discharged. You must call for an open appointment on the day you would like to receive therapy (appointments based on availability.)

I UNDERSTAND AND HEARBY AGREE TO ADHERE TO THE THERAPY ATTENDANCE POLICY.

Patient/Guardian Signature: _____ Date: _____/_____/_____

CLINICAL INFORMATION

Patient Name: _____ Occupation: _____

Gender assigned at birth: Male ☐ Female ☐ Height: _____ Feet _____Inches Weight: _____

Gender Identity: Male ☐ Female ☐ Non-Binary ☐ Choose not to disclose ☐

Treatment Area: _____

Date Symptoms Started: _____ Surgical Date: _____ Next Doctors appointment: _____

Referring Doctor: _____ Primary Care Doctor_____

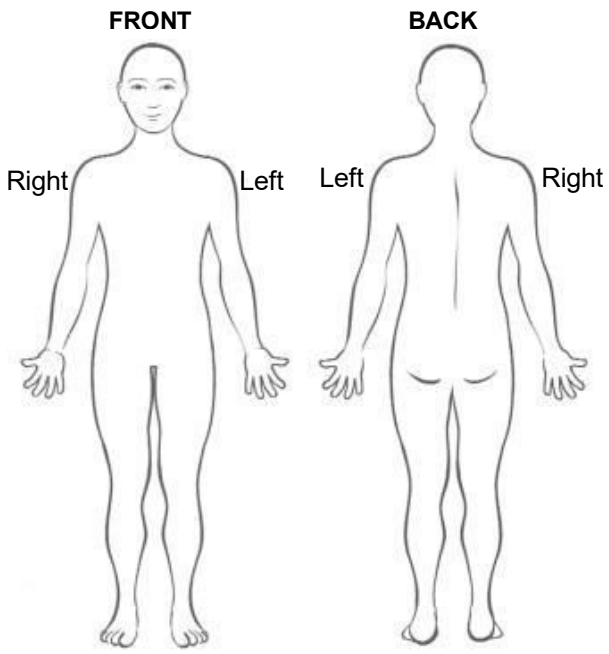
Allergies: _____

_____ Injections: ☐ Yes ☐ No When: _____

Your Pain Level in the PAST WEEK: (CIRCLE ONE)

	No Pain										Worst Pain
Lowest:	0	1	2	3	4	5	6	7	8	9	10
Current:	0	1	2	3	4	5	6	7	8	9	10
Highest:	0	1	2	3	4	5	6	7	8	9	10

Please Place an "X" on the Area of Pain



Describe Your Pain:

- ☐ Burning
- ☐ Sharp
- ☐ Achy
- ☐ Throbbing
- ☐ Numbness/Tingling
- ☐ Other: _____

*PLEASE FILL OUT THE BACKSIDE OF THIS FORM & SIGN

PAST MEDICAL HISTORY

- ☐ No Known Significant Past Medical History
- ☐ Alzheimer's or Dementia
- ☐ Cerebral Vascular Accident(Stroke)
- ☐ Diabetes Mellitus Type 1/ Type 2
- ☐ Fibromyalgia
- ☐ Immune Disorders or Immunosuppression
- ☐ High Blood Pressure
- ☐ History of Cancer
- ☐ Parkinson's Disease
- ☐ Traumatic Brain Injury/Concussion
- ☐ Osteoarthritis
- ☐ Osteopenia/Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ High Cholesterol
- ☐ Neurologic Disorders
- ☐ Back or Neck Pain
- ☐ Heart Attack (Myocardial Infarction)
- ☐ Congestive Heart Failure/ Heart disease
- ☐ Pulmonary Conditions (COPD/Emphysema)
- ☐ Kidney/Bladder Problems
- ☐ Gastrointestinal Issues
- ☐ Pacemaker / Prosthesis / Implants
- ☐ Visual Impairments
- ☐ Sleep Dysfunction
- ☐ Headaches/ Migraines
- ☐ Asthma
- ☐ Allergies
- ☐ Depression
- ☐ Anxiety or Panic Disorders

Other Medical History/ Surgeries: _____

_____

CURRENT MEDICATIONS

Prescription, Over-the-Counter Medications, & Supplements	Frequency	Dosage
☐ **SEE ATTACHED LIST WITH ALL CURRENT MEDICATIONS, FREQUENCY, AND DOSEAGES**		

SIGNATURE REQUIRED- *I attest that all the information provided is current and accurate as of today's date.*

Print Name (Full): _____

Patient Signature: _____ Date: _____

Guardian Signature: _____ Relationship to Patient: _____