DRUM HILL
PHYSICAL & SPORTS THERAPY

PATIENT INFORMATION

Name: _____ Nickname: _____ Age: _____

DOB: _____ / _____ / _____ Height: _____feet _____ inches Weight: _____ pounds

Gender : ☐ Male ☐ Female Cell Phone: (_____) _____ - _____ House Phone: (_____) _____ - _____

Occupation: _____ Email: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Emergency Contact Phone: (_____) _____

CLINICAL INFORMATION

Treatment Area: _____

Date Symptoms Started: ____ / ____ / _____ *Surgical Date*: ____ / ____ / _____ Injections: ☐ YES / ☐ NO

Referring Physician: _____ Next Doctor's Appointment Date: _____ / _____ / _____

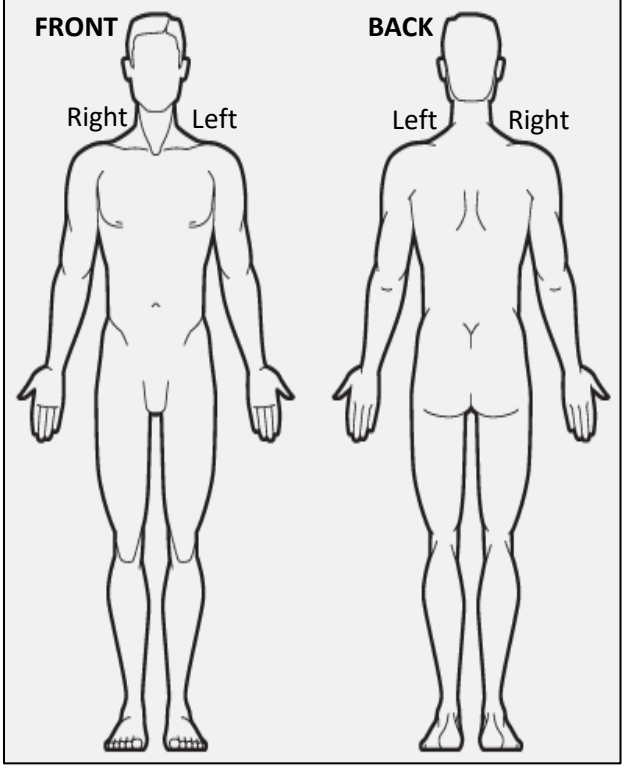
Your Pain Level in the PAST WEEK: (CIRCLE ONE)

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

Describe Your Pain:

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

Please Place an "X" the Area of Pain



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PAST MEDICAL HISTORY

- ☐ No Known Significant Past Medical History
- ☐ Alzheimer's or Dementia
- ☐ Cerebral Vascular Accident (Stroke)
- ☐ Diabetes Mellitus Type 1 / Type 2
- ☐ Fibromyalgia
- ☐ High Blood Pressure
- ☐ History of Cancer
- ☐ Immune Disorders or Immunospression
- ☐ Parkinson's Disease
- ☐ Traumatic Brain Injury / Concussion
- ☐ Osteoarthritis
- ☐ Osteopenia / Osteoporosis
- ☐ Rheumatoid Arthritis

Other Medical History / Surgeries: _____

_____

- ☐ 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 / Prothesis / Implants
- ☐ Visual Impairments
- ☐ Hearing Impairments
- ☐ Sleep Dysfunction
- ☐ Headaches / Migraines
- ☐ Asthma
- ☐ Allergies
- ☐ Anxiety or Panic Disorders
- ☐ Depression

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: _____

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CANCELLATION & NO-SHOW APPOINTMENT POLICY

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

A $25.00 missed fee will be charged on your second no-show and 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 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 possible discharge. 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: _____ / _____ / _____

INSURANCE INFORMATION

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PHYSICAL & SPORTS THERAPY

Primary Insurance: _____ Secondary Insurance: _____

Subscriber Name: _____ Relationship to Subscriber: _____

Subscriber DOB: _____ / _____ / _____ Primary Care Physician: _____

Are you being treated today for: ☐ Motor Vechile Accident ☐ Workman's Compensation Injury ☐ Not Appliable

Physical therapy in last 12 months? ☐ YES / ☐ NO Home Care in last 12 months? ☐ YES / ☐ NO

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. 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 for by insurance.

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

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 information above, I agree to fully cooperate and participate in all physical therapy 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 to treat letter. I authorize release of my medical information to appropriate third parties. I have seen the notice of information practice regarding patient privacy laws and provisions posted by the front desk.

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

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