PATIENT INFORMATION

PLEASE PRINT

NAME_____ **DATE OF BIRTH**_____ **AGE**_____

NAME OF PARENT/GUARDIAN IF MINOR_____

ADDRESS_____ **CITY**_____ **ST**_____ **ZIP**_____

CELL#(_____)_____ **HM#**(_____)_____ **WK#**(_____)_____
****MAY WE LEAVE MESSAGES AT THESE NUMBERS?** Y N - CL HM WK**

MAY WE CONTACT YOU VIA EMAIL? Y N EMAIL_____

EMERGENCY CONTACT_____ **PHONE#**(_____)_____

REFERRAL_____

PHONE#(_____)_____ **FAX#**(____)_____

FINANCIAL AND INSURANCE RESPONSIBILITIES

We have elected to no longer be a preferred provider for insurance companies. Instead, we provide physical therapy on a **"pay at time of service"** basis. By removing ourselves from contracted status with insurance companies, we do not have to limit the time or quality of treatment we provide because of insurance company restrictions or elevate our rates to pay for billing services.

We recommend you call your insurance company to completely understand your physical therapy benefits.

At the time of service and payment, you will receive a printed statement which you can submit to your insurance company for their consideration of reimbursement to you. We will provide chart notes or other documentation for you or your insurance company's written request. We cannot make guarantees or estimates regarding what reimbursement your plan allows.

I agree to pay DPT for my treatments at time of service, by cash, check, or debit, Visa, MasterCard or Discover.
_____**(Initial)**

CANCELLATION POLICY

I understand if I cancel more than 24 hours in advance, I will not be charged a cancellation fee. I understand if I cancel less than 24 hours in advance, I will pay a cancellation fee of $75.00. _____**(Initial)**

By signing this document I agree to the conditions stated in this form:

Patient/Guardian Signature_____ **Date**_____

CONDITIONS & CONSENT FOR PHYSICAL THERAPY AT DESERT PT

COOPERATION WITH TREATMENT

I understand that in order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances that prevent me from attending therapy. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist. _____**(Initial)**

NO WARRANTY

I understand that the physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist can share with me opinions and available statistics and studies regarding results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.
_____**(Initial)**

INFORMED CONSENT FOR TREATMENT

The term "**informed consent"** means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. The therapist provides a wide range of services. I understand that I will receive information at the initial visit concerning the treatment and options available for my condition. I understand that I can decline any portion of the evaluation or treatment at any time. _____**(Initial)**

Please initial one below:

_____I would like a witness in the room for physical therapy evaluation and/or treatment.
_____I do not need a witness

Potential risks: You may experience an increase in your current level of pain or discomfort, or an aggravation of your existing injury or condition.

Potential benefits: May include an improvement in your symptoms and an increase in your ability to perform daily activities. You may experience increased strength, awareness, flexibility and endurance in your movements. You will have greater knowledge about managing your condition and the resources available to you.

Alternatives: All physical therapy treatment options available to your conditions will be explained to you. You may inquire about the cost of these services and discuss them with your therapist. If you do not wish to participate in the therapy program, you may discuss your medical, surgical or pharmacological alternatives with your primary care physician._____**(Initial)**

I have read the above information and I consent to physical therapy evaluation and treatment. I understand the risks, benefits, and alternatives to treatment. I hereby voluntarily consent to physical therapy treatment. I understand that I may choose to discontinue treatment at any time.

_____ _____/_____/_____

Patient/Guardian Signature **Date**

****FOR THERAPIST USE ONLY*****

Consent to evaluation/treatment was verbally discussed with patient.

_____ _____/_____/_____

Therapist Signature Date

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

PATIENT NAME:_____ DOB:_____

Notice of Privacy Practices

The notice provides the uses and disclosures of my protected health information (PHI) that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that if I have questions or complaints regarding my privacy rights I may contact the person below.

I understand that the practice reserves the right to change the terms of its Notice of Privacy Practices. *I can obtain this practice's current Notice of Privacy Practices online or at the clinic upon request*.

_____ _____

PATIENT/GUARDIAN SIGNATURE ***DATE***

____Patient refused to Sign

____Patient was unable to sign because_____

Contact Person: Erika Townsend, PT, DPT – (602) 264-3369

DESERT PHYSICAL THERAPY & PELVIC HEALTH
5040 E. Shea Blvd.,#261
Scottsdale, AZ 85254

DESERT PHYSICALTHERAPY & PELVIC HEALTH
5040 E. SHEA BLVD., SUITE 261
SCOTTSDALE, AZ 85254
Phone: 602-264-3369 Fax: (602) 264-3368

Date: _____

History Form

Patient Name: _____
DOB:_____ **Referring Provider:** _____
Currently working? Yes or No **Occupation:** _____
Reason for Physical Therapy: _____
_____
When did this problem start? _____
Did a specific incident cause it? If yes, please describe: _____
_____
Are your symptoms_____staying the same,_____getting better,_____getting worse?

Have you had physical therapy in the past for these symptoms? Yes or No (circle)

What are your goals for Physical Therapy?_____

Medications (include reasons and supplements): _____

_____

Allergies: _____

Since the onset of your current symptoms have you had:

Y/N Fever/Chills Y/N Malaise (Unexplained tiredness)
Y/N Unexplained weight change Y/N Unexplained muscle weakness
Y/N Dizziness or fainting Y/N Night pain/sweats
Y/N Change in bowel or bladder functions Y/N Numbness / Tingling
Other /describe: _____

Please indicate if you are experiencing or have experienced any of the following:

	Anemia		Hearing Loss		Osteoporosis
	Arthritis		Hepatitis		Pacemaker
	Asthma		High Blood pressure		Pelvic Pain
	Blood Disorders		HIV/AIDS		Physical Abuse
	Cancer		Hypo/Hyperthyroid		Sexual Abuse
	Depression		IBS		STD's
	Diabetes		Interstitial Cystitis		Stroke
	Epilepsy/Seizures		Kidney Disease		TIA
	Head Injury		Low back pain		TMJ
	Headaches		Neck pain		Vision Problems

Anything other conditions that I should be aware of? _____

Surgeries	**Date**	**Reason**
Abdominal		
Bladder		
Bowel		
Uterine		
Orthopedic/Spine		
Heart		
Lungs		
Plastics		
Other		

Childbearing History

Are you currently Pregnant? Yes/No Due Date:_____
Number of Children:_____ Number of Vaginal deliveries:_____
Number of C-sections:_____ Number of episiotomies:_____
Number of forceps deliveries:_____ Any complications?:_____

Current Sexual Activity? (check all that apply)

____Sexually Inactive due to pain
____Pain with Penetration ____Pain with Climax
____Pain after intercourse? How long does it last? _____
____Sexually inactive due to other reasons
____No pain with intercourse

Bladder:

Y / N Difficulty initiating urine stream? **Y / N** Pain during urination?
Y / N Sensation of incomplete bladder emptying? **Y / N** Blood in urine?
Y / N Urine loss with sneezing, coughing, laughing? **Y / N** Insensible urine loss?
Y / N Urine loss with urgency to void? **Y / N** Dribbling after urination?
Y / N Straining to empty bladder?
Is urine stream **weak**, **strong**, or **does it stop start**? (circle)
How many times a day do you void?_____ Per Night?_____
Do you wear pads? **Yes** or **No** How many per day/week? _____
Do you have a sensation of something "falling out"? **Yes** or **No**

Bowel:

Y/N Loss of stool beyond your control? **Y/N** Straining to empty bowels?
Y/N Pain during bowel movements? **Y/N** Sensation of incomplete bowel movements?
Y/N Loss of flatulence (gas) beyond your control?
How Many bowel movements per day/week? _____
Is your stool (circle): **Loose/Liquid Soft Hard Pellets**

If you are experiencing pain, please indicate your pain level below:

0_____10

0= no pain **10=ER Visit**

How would you describe your pain? (circle all that apply)

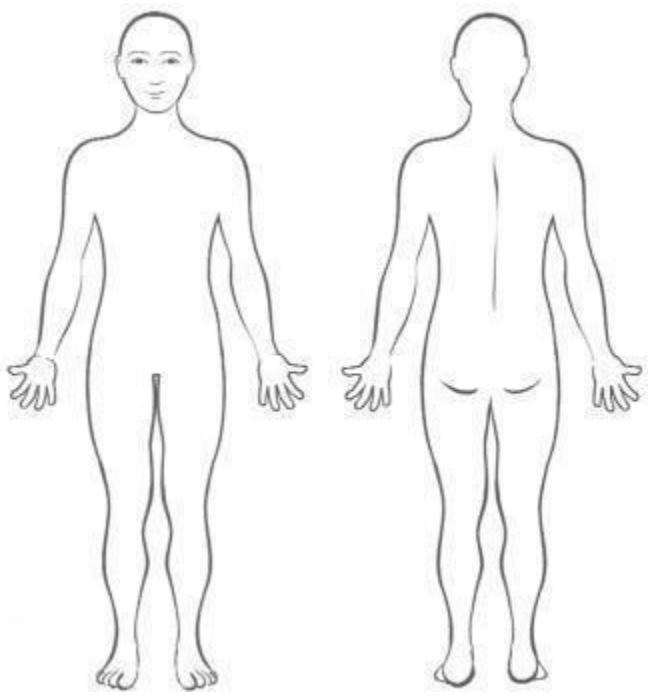
Aching	Stabbing	Shooting	Sharp	Dull
Constant	Tingling	Intermittent	Pressure	Numb

Other: _____

What increases your pain? _____

What decreases your pain? _____

Indicate where you are having pain below:



Front **Back**

Please indicate your stress level below:

0=no stress **10= extreme stress**