ReQuest PHYSICAL THERAPY
*Comprehensive care with a personal touch*

# PATIENT SUMMARY

*To better serve you, it is important that you complete this medical history as completely and as accurately as possible*

## PART IA PERSONAL INFORMATION

Name (as you like to be addressed) _____

Mailing Address _____

_____

Age ____ Date of Birth _____ Home Phone Number (____)_____ Email_____

Date of Initial Injury _____ Referring Physician _____

Date of Most Recent Increase of Symptoms _____ Primary Care Physician _____

Please check the appropriate response

| | YES | NO |
|---|---|---|
| Do you smoke? | | |
| Do you exercise regularly? | | |
| Is your current condition work accident related? | | |
| Is your current condition auto accident related? | | |
| Have you had physical, occupational, speech, massage or chiropractic care for any reason this year? | | |

## PART I PAST MEDICAL HISTORY

Please check YES if you have ever (in your life) had, or do you presently have any of the following

| | | YES |
|---|---|---|
| 1 | Anemia / Blood Disease | |
| 2 | Bone / Joint Problem | |
| 3 | Arthritis / Rheumatism | |
| 4 | Allergies | |
| 5 | Back Trouble | |
| 6 | Breathing Problems (any kind) | |
| 7 | Broken Bones / Dislocation / Sprains | |
| 8 | Cancer or Tumor | |

| | | YES |
|---|---|---|
| 9 | Diabetes | |
| 10 | Dizziness / Fainting | |
| 11 | Epilepsy / Seizure Disorder | |
| 12 | Fibromyalgia Syndrome | |
| 13 | Headaches | |
| 14 | Head / Spinal Injury | |
| 15 | Heart Disease / Chest Pain | |
| 16 | Hernia / Rupture | |

| | | YES |
|---|---|---|
| 17 | High Blood Pressure or High Cholesterol | |
| 18 | Lung Disease | |
| 19 | Paralysis | |
| 20 | Pregnancy (Current) | |
| 21 | Skin Disease or Sores That Won't Heal | |
| 22 | Stroke | |
| 23 | Swelling of Feet or Joints | |
| 24 | Other | |

Please give details of all above YES answers below (listing the corresponding number)

| Number | Illness Details |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Please continue on Back**

## PART II PAST SURGERIES

If you have had any prior surgeries please give details below

| Surgery / Procedure | Date |
|---|---|
| | |
| | |
| | |
| | |
| | |

## PART III MEDICATIONS

Are you allergic to any medications? YES / NO If YES, what? _____

If you are currently taking any medications please list below

| | Medication |
|---|---|
| 1 | |
| 2 | |
| 3 | |
| 4 | |

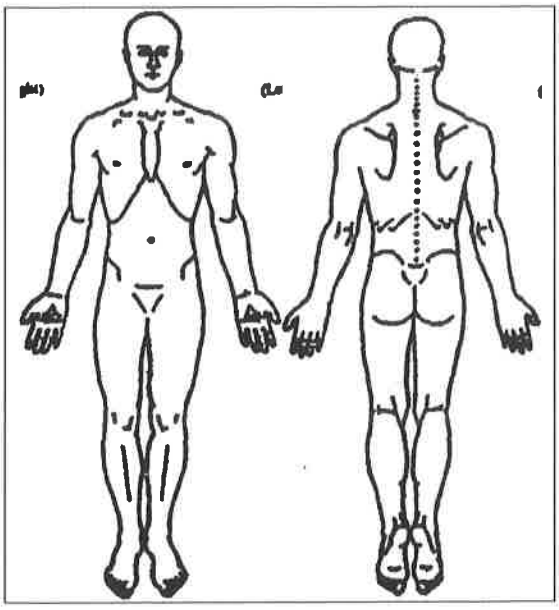
| | Medication |
|---|---|
| 5 | |
| 6 | |
| 7 | |
| 8 | |

## PART IV PAIN LEVEL EVALUATION

Using the 0 to 10 scale below, please circle your pain level during the last week

Using the chart below and to the right, please indicate with an "X" the location of any pain, numbness or tingling you have experienced during the last week

No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain



*"I certify that I have reviewed and understand the above information supplied by me, and that it is true and correct to the best of my knowledge"*

_____ _____

**Patient Signature** **Date**

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## PATIENT ATTENDANCE POLICY

In order to assure that all patients receive the time and attention they deserve, the following guidelines have been established:

1. If you arrive late for a scheduled appointment, you may not be able to be seen that day.

2. If you need to cancel an appointment, please notify us as soon as possible. If we are unable to take your call, please leave a message on our voicemail.

3. If you cancel with less than 24 hours notice or no show a scheduled appointment:
   - The first cancellation/no show fee will be waived.
   - On the second and any subsequent occurrence, you may be charged a $25 fee.

Please note that any cancellation/no show fees are at the discretion of the treating therapist and/or the front desk manager. If you fail to keep scheduled appointments, you may be discharged from therapy.

*"I have read and understand this policy"*

Patient Name (please print) _____

Patient / Guardian Signature _____ Date _____

## CONSENT TO DISCLOSE PATIENT INFORMATION / HIPAA

*"I understand this center's Notice of Privacy Practices and give permission for my protected health information to be disclosed for purposes of communicating results, findings, care decisions and appointments to the family members or friends listed below:"*

Name _____

Name _____

Name _____

Name _____

Patient Name (please print) _____

Patient / Guardian Signature _____ Date _____

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## INSURANCE ASSIGNMENT AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION

RELEASE OF INFORMATION I, the below named patient, hereby authorize ReQuest Physical Therapy to release to any third party payer (such as an insurance company or governmental agency, example: Blue Cross of Florida or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

THERAPIST/CENTER INSURANCE ASSIGNMENT I, the below named patient, hereby authorize payment directly to ReQuest Physical Therapy and/or any therapist examining or treating me for any group and/or individual medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services. I understand and agree that the center providing services is based on a treatment team approach to care. The treatment team consists of physical therapists, physical therapist assistants, licensed massage therapists, exercise specialists, athletic trainers and interns in training working under the direction and supervision of the treating physical therapist.

MEDICARE PATIENT'S CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST I, the below named patient, certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration\Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare claim. I hereby certify all insurance pertaining to treatment shall be assigned to the center/therapist treating me.

MY RESPONSIBILITY I, the below named patient, understand it is my responsibility to pay at time of service any deductible amount, co-payment, co-insurance or any other balance not paid for by my insurance. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL, WHICH IS ON FILE AT REQUEST PHYSICAL THERAPY. This assignment will remain in effect until revoked by me in writing.

Patient Name (please print) _____

Patient / Guardian Signature _____ Date _____