# PATIENT INFORMATION

LAST NAME:_____ FIRST NAME: _____MI: __

D.O.B: ____/____/____ MARITAL STATUS: _____ SEX: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE:_____

MAILING ADDRESS (IF DIFFERENT): _____

CITY:_____ STATE:_____ ZIP CODE: _____

BEST PHONE NUMBER TO CONTACT YOU:_____M/H/O

EMAIL ADDRESS: _ _____

EMERGENCY CONTACT/ LEGAL GUARDIAN:_____

RELATIONSHIP TO PATIENT: _____

CONTACT PHONE NUMBER: _____

NAME OF PRIMARY CARE OR REFERRING PHYSICIAN: _____
_____

CONTACT INFO FOR PRIMARY CARE OR REFERRING PHYSICIAN: _____
_____
_____
_____

# REASON FOR VISIT

____INJURY ____ ACCIDENT ____ SURGERY

DESCRIBE YOUR CURRENT INJURY _____

_____

_____

_____

WHEN DID YOUR SYMPTOMS BEGIN?:_____

_____

WHAT DO YOU THINK CAUSED THEM? WHY?:_____

_____

_____

SINCE ONSET HAVE YOUR SYMPTOMS: ____ BECOME WORSE ____ BETTER ____ NO CHANGE

WHAT INCREASES YOUR SYMPTOMS? _____

_____

WHAT EASES YOUR SYMPTOMS?_____

_____

DESCRIBE ANY RELEVANT PREVIOUS INJURIES:_____

_____

_____

_____

DESCRIBE ANY OTHER RELEVANT MEDICAL HISTORY THAT YOUR THERAPIST SHOULD BE AWARE OF: _____

_____

_____

_____

HAVE YOU UNDERGONE ANY DIAGNOTIC TESTING? (I.E. MRI, XRAY, EMG ETC.):

_____

WHAT ARE YOUR GOALS FOR TREATMENT?: _____

_____

## Review of Systems

| YES | NO | |
|---|---|---|
| __ | __ | **General** (poor general health, unexplaned weight loss, fatigue) |
| | | **Skin** (rashes, lesions, changes in moles) |
| | | **Eyes** (blurred vision or a change in visual acuity) |
| | | **Ears** (ear pain, ringing in the ears, hearing difficulty) |
| | | **Nose** (nasal congestion, discharge, bleeding) |
| | | **Mouth/Throat** (difficulty swallowing, sore throat) |
| | | **Respiratory** (shortness of breath, coughing, sneezing) |
| | | **Cardiovascular** (nausea, high or low blood pressure, palpitations) |
| | | **Gastrointestinal**(vomiting, diarrhea, constipation, abdominal pain) |
| | | **Irregular Bowl Movements** (less than one per day) |
| | | **Genitourinary** (problems inititiating/controlling bladder) |
| | | **Women's Health** (pain with intercourse, painful menstrual cycle) |
| | | **Endocrine** (heat or cold tolerance, weight loss or gain) |
| | | **Bone Health** (osteopenia, osteoporosis, etc) |
| | | **Psychiatric** (depression, anxiety, suicidal thoughts) |
| | | **Smoking** (occasional, daily) |

**Describe** _____

_____

_____

_____

_____

_____

_____

**MEDICATIONS and reason for taking:** _____

_____

_____

_____

_____

_____

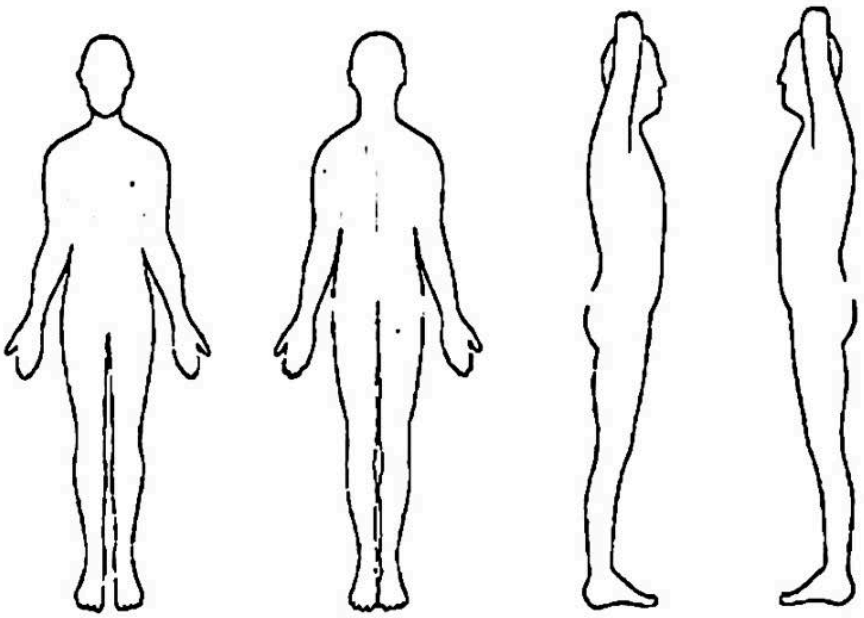
_____

_____

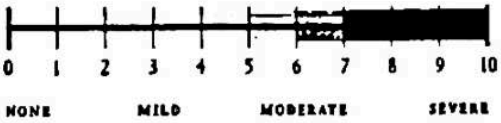
Draw on the figure below where you feel or have felt related pain and/or symptoms.

SYMPTOMS YOU FEEL TODAY: *Use "X" marks*

SYMPTOMS PRIOR TO TODAY: *Use "O" marks*



Please indicate the intensity of current, best, and worst pain levels over the past 24 hours on a scale of 0 (no pain) to 10 (worst pain imaginable)"




Current ___ / 10 Best in past 24 hours ___ / 10 Worst in past 24 hours ___ / 10

## PRIVACY PRACTICES

Your records will not be disclosed to others unless directed by you or an authorized legal authority.

## AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION

The best number to leave a detailed message on voicemail

is:_____

The best email address to leave a detailed message is:

_____

## RELEASE OF INFORMATION/ASSIGNMENT OF INTEREST

I authorize Resilience: A Physical Therapy and Pilates Studio to release any information requried for treatment. I consent to receive treatment as prescribed by my doctor or recommended by my PT. My PT will discuss the plan of care at the end of the initial evaluation.

signed_____
_____

dated_____

# PHYSICAL THERAPY BILLING POLICIES

## LATE CANCELLATION POLICY

There is a 24 hour cancellation policy. If you cancel within 24 hours before an appointment or if you do not show at all, you will be billed $100, payable before your next appointment can take place.

## PAYMENT

rates ARE $160 for an initial evaluation and $140 for follow up visits. Payments can be made with cash, check or credit card.

## TERMS OF PAYMENT

I am financially responsible for any balance due within 30 days of invoice. I have read and understand the Resilience billing policy.

signed_____
_____

dated_____

Thank you for your compliance and understanding. I value your patronage.