
First name Middle Initial

Last Name

Date of Birth
Month Day Year

Social Security Number _____

Address: _____

City State Zip

Cell phone number: _____

Home phone number: _____

Can we leave detailed voicemails? Home Cell

Appointment reminders:

Emergency Contact:

Name: _____

Phone: _____

Please choose the appropriate answers below:

Gender: _____ **Marital Status:** _____

Employment status: _____

Occupation: _____

Social History:

Are you a veteran or active member of the military?

Do you have a history of trauma or abuse?
Physical Sexual Emotional

Are there any cultural or religious beliefs you would like your therapist to be aware of? Please Explain:

Have you experienced any major life changes in the past year? (i.e. moving, job change, birth of child, death of a loved one) Please Explain:

Living Environment:

Who lives with you?

Do you feel safe at home?

General Health Questions:

Smoking/tobacco history: Never Past Current
Cigarettes/day _____ Years quit _____

Alcohol consumption:
Drinks _____ per:

Recreational/illicit substance use/abuse:
Never Past Current

Substance(s): _____

Regular Exercise: Days/week _____
Type: _____

Do you want accountability to help you:

- Quit smoking?
- Lose weight?
- Fight Addiction?

Have you fallen in the last 12 months?
How many times? ____ Did injury occur?

Hand dominance: Right Left Ambidextrous

Preferred learning style: (check all that apply)
 Auditory Visual Kinesthetic

Over the past 2 weeks, how often have you been bothered by any of the following problems?

- 1.) Little interest or pleasure in doing things
- 2.) Feeling down, depressed, or hopeless

Please rate your overall health:

Excellent Good Fair Poor

Patient Signature: _____ Date: _____

Medical History

Primary Care Physician: _____

Referring Provider: _____

Are you seeing other providers? (check all that apply)

- Acupuncture ENT Orthopedic
- Allergist GI Specialist Pain Specialist
- Cardiology Massage Podiatry
- Chiropractor Naturopath Psychiatry
- Counsellor Neurology Rheumatology
- Dentist OB/GYN Speech therapy
- Dietician OT Surgeon

Other: _____

Have you had diagnostic imaging/testing?

Other testing: _____

Allergies: List all allergies to medications, latex, foods, and environmental allergens.

MEDICATIONS: List all medications (prescription and non-prescription), nutritional supplements, and homeopathic remedies you are currently taking.

SURGERIES: List all surgeries and the year performed

Height: _____ Weight: _____

Medical History: Mark all conditions that apply

- Arthritis Blood disorders
- Broken bones Hepatitis
- Osteoporosis HIV/AIDS
- Heart problems Skin diseases
- Pacemaker Thyroid problem
- High blood pressure Depression
- Dysautonomia/POTS Anxiety
- Asthma Anemia
- Lung problems Lupus
- Hypoglycemia (low blood sugar) Fibromyalgia
- Diabetes Ehlers Danlos (EDS)
- Cancer Stomach problems
- COVID-19 Hernia
- Memory problems Kidney problems
- Head injury / Concussion Urinary incontinence
- Seizures / Epilepsy Irritable Bowel (IBS)
- Headaches / Migraines Muscular Dystrophy
- Stroke Cerebral Palsy
- Multiple Sclerosis Congenital problems
- Parkinson's disease Other _____
- Circulation/vascular problems _____

Within the past year, have you experienced any of the following:

- Chest pain Joint pain/swelling
- Heart palpitations Pain at night
- Cough/Hoarseness Difficulty sleeping
- Shortness of breath Difficulty swallowing
- Dizziness Loss of appetite
- Blackouts/Fainting Weight gain / loss
- Headaches Nausea/vomiting
- Weakness in arms/legs Fevers/chills/sweats
- Difficulty in walking Hearing problems
- Coordination problems Vision problems
- Tremors Loss of smell
- Bowel problems Ear ringing/tinnitus
- Urinary problems Other _____
- Changes in sexual function _____

Males: History of prostates disease

Females: History of

- Pelvic Inflammatory (PID) Trouble with periods
- Polycystic ovarian (PCOS) Endometriosis
- Currently pregnant _____ Past pregnancies ____
- (weeks)

Patient Signature: _____ Date: _____

History of present condition:

Describe what condition(s)/problem(s) bring you to therapy today: _____

How did the injury happen or how did the problem start? _____

When did the problem begin? _____

Did you have surgery for this problem?

Date of surgery _____

Were you hospitalized?

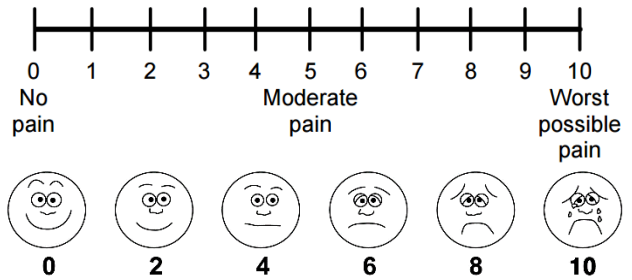
Date of discharge from hospital _____

Therapy Goals:

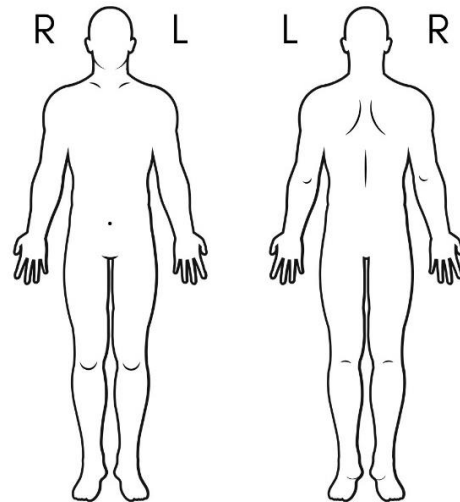
What are your goals for physical therapy?

Please rate your average daily pain:

Choose one number:



Please shade the area(s) of your pain below.



Please list 3 functional/daily activities that you have difficulty with or are unable to perform as a result of your injury or problem. Three functional limitations are typically **REQUIRED** by insurance companies to justify coverage for physical therapy treatment.

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Unable to perform activity

Able to perform activity the same as before the injury

| Activity Limitation | Score 0-10 |
|---------------------|------------|
| | |
| | |
| | |

Legal Questions: If answered yes, additional documentation/fees may be required.

- 1.) Is there pending litigation associated with your injury/condition?
- 2.) Do you have a pending disability case?
- 3.) Is this injury associated with a motor vehicle accident?
- 4.) Is there a workmen's compensation case associated with this injury?

Patient Signature: _____ Date: _____

HIPPA

Patient’s Written Acknowledgement of Privacy Practices:

I, _____ acknowledge that I have been granted access to the notice of privacy practices and was given the ability to request a copy of Ally Total Physical Therapy’s Notice of Privacy Practices and fully understand. I further acknowledge that I have had all my questions answered to my satisfaction regarding privacy practices. I hereby authorize Ally Total Physical Therapy to disclose my protected health information to the following

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Patient Signature _____ Date _____

Guardian Signature _____ Date _____

CONSENT TO TREAT

I understand that I have been referred for or elected to pursue Physical Therapy Treatment to Ally Total Physical Therapy LLC. Ally Total Physical Therapy LLC has described for me the process of physical therapy evaluation and my individual treatment plan. I understand that I have the right to ask questions and have any questions answered prior to receiving any evaluative testing or treatment, including any risks or alternatives to this treatment plan that has been prescribed for me by my physician and/or recommended by my physical therapist. By signing this agreement, I consent to have Ally Total Physical Therapy LLC provide treatment and care as prescribed for me by my physician and/or recommended by my physical therapist.

Patient Name _____ Date _____

Patient Signature _____ Date _____

CONSENT TO TREAT A MINOR

I hereby state that I am the legal guardian for the below referenced patient and I authorize the physical therapists and whomever they may designate as assistants at Ally Total Physical Therapy to administer physical therapy treatment care as deemed necessary to my minor child. I understand that at any time I am responsible for communicating any questions that I may have in regard to treatment to the treating therapist or supervision therapist at the facility. I further understand it is my responsibility to understand upon conclusion of the evaluation appointment the indications and contraindications for treatment and should notify the evaluating therapist if I do not understand. This consent shall remain in effect through the course of treatment unless revoked in writing.

Printed Name of Parent or Legal Guardian: _____

Address: _____ Phone: _____

Signature of Parent or Legal Guardian: _____

FINANCIAL STATEMENTS AND DISCLOSURES

I understand that I am responsible for all fees to be paid at the time of service. _____ (initial)

I understand that Ally Total Physical Therapy is a cash based physical therapy practice and does not have contracts with any health insurance companies. I have been informed that I have a right to seek services from other physical therapy providers who may accept my insurance. I am choosing of my own free will to seek services at Ally Total Physical Therapy knowing that they will not directly bill my insurance company on my behalf, and are not a contracted provider with my insurance. _____ (initial)

I understand that I have a right to request bill from Ally Total Physical Therapy. I have been informed that some insurance companies will accept bills submitted directly by patients for reimbursement. I have been advised that this is not true of all insurance companies. I recognize and accept that it is my responsibility as a patient to contact my insurance company to determine my individual insurance coverage for physical therapy services prior to attending physical therapy. I understand that if I wish to seek reimbursement from my insurance company, I must confirm with my insurance that I can be reimbursed directly. Ally Total Physical Therapy does not accept payments from insurance companies to be redistributed to patients. _____ (initial)

No Show/Cancellation Policy

I understand that I am required to provide 24 hour notice of cancellation for my appointment. If less than 24 hours notice is given, I acknowledge that a cancellation fee of \$25 will be charged.

It is company policy that after 2 consecutive no-showed appointments, or three consecutive cancelled appointments, my case will be placed on same-day scheduling. This policy is in effect to ensure fair and equitable availability of physical therapy appointments for all patients.

Printed Patient Name: _____

Patient Signature: _____ Date: _____