_____ _____
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: Yes / No Text or Email

Emergency Contact:

Name: _____
Phone: _____

Please (circle) the appropriate answers below:

Gender: Male Female Prefer not to Answer

Marital Status: Single Married Divorced Widow

Employment status: Full Time Part Time Retired Homemaker Student Unemployed Disabled

Occupation: _____

Social History:

Are you a veteran or active member of the military?
Not Applicable Army Navy Marines Corps
Airforce Coast Guard National Guard

Do you have a history of trauma or abuse? Yes / No
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: (circle) below

Who lives with you? Alone Spouse Child(ren)
Roommate(s) Other relative(s)

Do you feel safe at home? Yes No

General Health Questions:

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

Alcohol consumption: Never Infrequent Regular
Drinks _____ per: day / week / month

Recreational/illicit substance use/abuse:
Never Past Current
Substance(s): _____

Regular Exercise: Days/week _____
Type: _____

Do you want accountability to help you:
Quit smoking? Yes / No
Lose weight? Yes / No
Fight Addiction? Yes / No

Have you fallen in the last 12 months? Yes / No
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?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

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? (Circle)

X-rays MRI CT scan Ultrasound EMG EKG Echocardiogram Bloodwork Other:_____

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 Yes / No

Females: History of

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

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? Yes / No
Date of surgery _____

Were you hospitalized? Yes / No
Date of discharge from hospital _____

Therapy Goals:

What are your goals for physical therapy?

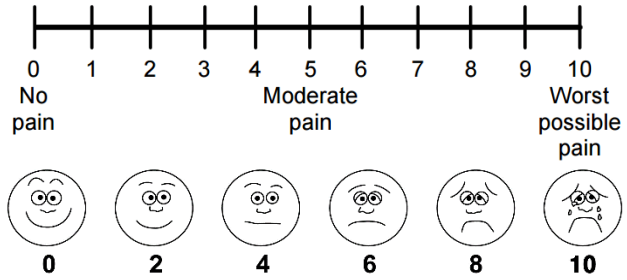
_____

_____

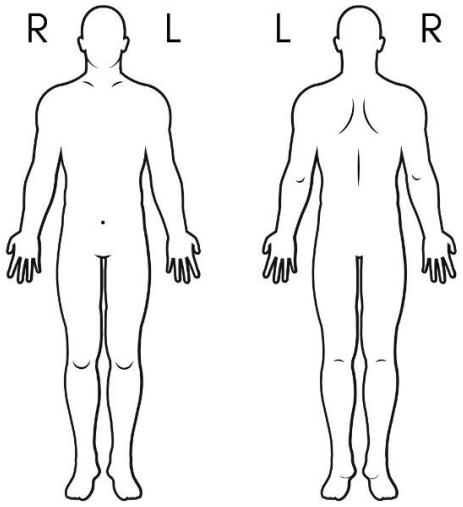
_____

_____

Please rate your average daily pain: Circle one number below.



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.

Yes / No 1.) Is there pending litigation associated with your injury/condition?
Yes / No 2.) Do you have a pending disability case?
Yes / No 3.) Is this injury associated with a motor vehicle accident?
Yes / No 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: _____

Witness: _____ Date: _____

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 LLC 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 LLC knowing that they will not directly bill my insurance company on my behalf, and are not a contracted provider with my insurance. If I have Medicare, I understand and have been notified that physical therapists cannot "opt-out" of Medicare. Ally Total Physical Therapy LLC does not knowingly provide services to Medicare patients. I attest that if I choose to receive services from Ally Total Physical Therapy LLC without disclosing my Medicare insurance coverage, I will not ask for a bill to be submitted to Medicare on my behalf at a later date. Furthermore, of my own free will I expressly prohibit Ally Total Physical Therapy LLC from billing Medicare on my behalf and hereby absolve them of the responsibility to do so. _____ (initial)

I understand that I have a right to request a 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 $35 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: _____

Witness Signature: _____ Date: _____