Movement
PHYSIOTHERAPY
Get Ready To MOVE Better

Patient Name:_____

Birthday:_____

Home Phone:_____

Email:_____

Address:_____

Physician's Name: _____

Diagnosis: _____ Injury: Work or Auto related? _____.

Allergies or Medical Precautions: _____.

Emergency Contact: _____ Phone#: _____

What is your major complaint_____

Start Date:_____ Symptoms:_____

Previous doctors seen for complaint: _____

Previous treatment for complaint:_____

Symptom-Aggravating Factors:_____

Symptom-Relieving Factors: _____

Time of Day Symptoms are Best:_____

Current Level of Pain 1 to 10:_____Is your pain getting better or worse? _____

Any Numbness or Tingling?_____

Has this problem affected your daily life or routine? Briefly describe in what ways._____
_____
_____

Have you had past similar episodes of this current problem? If yes, were you treated with; (circle disciplines, which apply) Physical Therapy, Acupuncture, M.D. (Meds, TPI's) Massage Therapist, Chiropractor, Pilates, General Exercise, exercise with trainer, Self medicated (Advil), ignored it, other, Did they help to alleviate your symptoms?_____
_____

Have you undergone any special tests for this condition? (X-rays, MRI's, ETC) If yes, do you know the results?_____
_____

Please answer the following questions: Yes No

1) Do the current problems interrupt your sleep?
2) Do your symptoms change with coughing or sneezing?
3) Have you had any recent changes in bowel or bladder function?
4) Do you experience any dizziness or vertigo?
5) Have you had any recent change in your weight or appetite?
6) Do you have any intolerance to hot or cold?
7) Do you have any bruising or bleeding disorders?
8) Have you had any skin changes, such as rashes or discoloration?
9) Have you experienced any changes in your vision, such as blurring, double vision, or decrease in your visual fields?
10) Have you had a recent episode of nausea/vomiting?
11) Are you pregnant?
12) Do you have osteoporosis? Date of your last bone scan:
13) Do you have any allergies?
14) Have you noticed any shortness of breath or decrease in exercise tolerance?
15) Do you use any assistive devise? (cane foot orthotics)
16) Do you have high blood pressure?
17) Do you have any cardiac problems?
18) Do you have diabetes?
19) Have you ever had cancer of any sort?
20) Do you have a history of neck or back problems?

Any other illness, past injuries I should be aware of?
_____ Past surgeries___yes, ___no, give brief details:_____ List the medications you are currently taking (over the counter/prescription):_____
_____
_____

Are you presently working? _____Yes, _____No, since:_____
_____
Physical/Emotional demands of present occupation? (High, moderate, minimal)_____
_____
Overall activity level: _____Sedentary, _____Light, _____Moderate, _____Heavy, _____Very heavy.
Sports and Exercise (Type, Frequency, Duration) _____
_____
Use of Tobacco ____Yes, ____no. Use of Alcohol ____Yes, ____No. Family medical History: Does any one in your immediate family (mother, father, siblings) have a history of Diabetes, High Blood Pressure, Cardiac Problems, or Cancer?_____
_____
_____
Please list 3 goals of Physical Therapy and time frames:
1)_____
2)_____
3)_____
Thank You for Your Patience and Valuable Time!!!

Movement Physio Therapy & Performance LLC Billing Policy, Release, and Authorization

I authorize Movement Physio Therapy & Performance LLC to bill my insurance company directly for the covered portion of charges, and I authorize payment of benefits directly to Movement Physio Therapy & Performance LLC I authorize Movement Physio Therapy & Performance LLC to release medical or other information necessary to process this claim. I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, my co-insurance or co-payment, and any charges not reimbursed by my insurance carrier. I understand that some insurance companies require medical or administrative pre-authorization for treatment, or have reimbursement limits on physical therapy treatments. I understand I am responsible for knowing and meeting the requirements of my insurance plan.

Movement Physio Therapy & Performance LLC Consent to Treat Agreement

Consent: I consent to and authorize Movement Physio Therapy & Performance LLC to administer physical therapy treatment under the direction and supervision of the physical therapist. I

understand and am informed that, as in the practice of medicine, physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform the physical therapist/staff about any health problems or allergies I have, as well as medications I am taking.

Signature:_____ Date:_____

Signature of Legal Guardian if patient is under age of 18_____