Today's date___________________

PATIENT INFO:

Name:____DOB:___________________

Home Phone: _________________________ Cell: ____________________Work:_____________________

Address: ____City:______________________State:_______Zip: _______

Email Address: ____

In case of emergency contact: _______________________________________ Relationship: ____________________
Home Phone: ____ Cell Phone: _________________________________

What are you being seen for?:________________________________Date Of Injury/Onset:_____/_____/____

Primary Care Physician: ____
Referring Physician: ____

Have you been prescribedphysical therapy by a specialist or your primary doctor? YES____ NO_____

Have you had any diagnostic or rehabilitative services for this injury? Yes______ NO_____
If yes, please indicate service and date: MRI __________ X-Rays ____________ PT/OT _____________________

How did you learn about our practice? ____

PARENT/GUARDIAN INFO: (If patient is under 18 yrs of age)

Name:____DOB:___________________

Home Phone: _________________________ Cell: ____________________Work:_____________________

Address: ____City:______________________State:_______Zip: _______

Email Address: ____

PLEASE INDICATE WHAT SERVICES YOU ARE INTERESTED IN:
(Check all that apply)

Physical Therapy	____	Physician Visit	____	Speed Training	____
Injury Rehab	____	Massage Therapy	____	Agility Training	____
Post-surgical Rehab	____	Metabolic Exercise	____	Strength Training	____
Injury Prevention	____	Weight Loss	____	Jump Training	____
Core Stabilization	____	Diet and Nutrition	____	Flexibility Training	____
Balance Training	____	Personal Training	____	Coordination Training	____
Gait Training	____	Postural Assessment	____	Sport Specific Training	____
Pre-natal Exercise	____	Post-partum Exercise	____		

Date:_________
Patient's Name: ____

INSURANCE INFORMATION:

Did your injury happen on the job?   YES NO   Is your injury due to an automobile accident? YES NO
If yes, what date did the injury occur? _______________________________________
Did you report the accident to your employer?   YES NO
Worker's Comp/Auto Claim #___________________________ Adjustor Name____________________

Our office will file insurance claims for all reimbursable services to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay, co-insurance and non-covered service amounts. See our complete financial policy for details.

I authorize the release of any medical information necessary to process my claim.**Initial:** ______________
I authorize payment of medical and surgical benefits to Revolution Physical Therapy. **Initial:** ____________

Signature of Patient/Parent/Legal Guardian: ____

Consent to Treat:

I (or my legal guardian or parent) hereby agree and authorize the providers of Revolution Physical Therapy to provide medical care reasonable by today's standards to treat my physical condition.

Patient's Name(please print): ______________________________ **DOB:** _______________

Signature of Patient/Parent/Legal Guardian:____

Date:_________
Patient's Name: ____

PAST MEDICAL HISTORY:

Please review the list below and check any problems you have had now or in the past

Abnormal Pap Smear		Eating Disorder		Migraines	
Acne		Eczema		Osteoarthritis	
ADD/ADHD		Emphysema		Osteopenia	
Alcohol Abuse		Frequent UTI's		Osteoporosis	
Anemia		Frequent Sinus Infections		Positive TB Skin Test	
Anxiety Disorder		Gallstones		Prostate Problems	
Asthma		Glaucoma		Psoriasis	
Bipolar Disorder		Gout		Reflux (heartburn)	
Blood Clot		Heart Attack		Rheumatoid Arthritis	
Blood Transfusion		Heart Condition (specify________________)		Rosacea	
Cancer (specify________________)		Hepatitis (specify A, B, C)		Seasonal Allergies	
				Seizures	
Chronic Bronchitis		High Blood Pressure		Sexually Transmitted Disease	
Crohn's Disease or IBS		High Cholesterol		Stomach Ulcers	
Colon Polyps		Kidney Disease		Stroke	
Depression		Kidney Infections		Tuberculosis	
Diabetes		Kidney Stones		Thyroid Disease	
Diverticulitis		Lupus		Ulcerative Colitis	
Drug Abuse		Melanoma or Skin Cancer		Warts	

Other medical problem not on list:
____

Please list all of the SURGERIES you have had and dates:

Date:
Date:
Date:
Date:
Date:

Date:_________
Patient's Name: ____

FAMILY HISTORY: Have any of your family members had any of the following problems?

	Condition	Family Member
	Heart Disease/Attack	
	Stroke	
	Diabetes	
	High Blood Pressure	
	High Cholesterol	
	Thyroid Disease	
	Depression	
	Other Mental Illness	
	Alcoholism	

	Condition	Family Member
	Asthma	
	Osteoporosis	
	Migraines	
	Breast Cancer	
	Colon Cancer	
	Prostate Cancer	
	Lung Cancer	
	Ovarian Cancer	
	Uterine Cancer	
	Skin Cancer	
	Other Cancer	

Any other illness in the family not listed? ____

MEDICATIONS:

Do you have any allergies to medications? YES NO KNOWN DRUG ALLERGY
If YES:
Medication: ________________________________ **Reaction:** ________________________________
Medication: ________________________________ **Reaction:** ________________________________
Medication: ________________________________ **Reaction:** ________________________________

Please list all prescriptions and over-the-counter medications:

Medication__________________________________ _____**mg Times taken per day**________
Medication__________________________________ _____**mg Times taken per day**________
Medication__________________________________ _____**mg Times taken per day**________
Medication__________________________________ _____**mg Times taken per day**________

Please list all herbal preparations and supplements that you take on a daily basis:

Description: ______________________________________ **Amount taken daily:** _____________
Description: ______________________________________ **Amount taken daily:** _____________
Description: ______________________________________ **Amount taken daily:** _____________

Preferred Pharmacy: _____________________________________ **Phone #** ___________________

Revolution
PHYSICAL THERAPY

Date:_________
Patient's Name: ____

MEDICAL SCREENING QUESTIONNAIRE

Cardiovascular System	**Yes**	**No**
Elevated Cholesterol	___	___
Sweating associated with pain	___	___
Palpations	___	___
Swelling of extremities	___	___
History of smoking	___	___
Orthopnea (difficulty breathing)	___	___

GI System	**Yes**	**No**
Difficulty Swallowing	___	___
Heartburn	___	___
Jaundice (yellow appearance)	___	___
Specific food intolerance	___	___
Constipation	___	___
Diarrhea	___	___
Change in color of stool	___	___
Rectal bleeding	___	___
Gall bladder problems	___	___
Liver problems	___	___

G.U. System	**Yes**	**No**
Dysuria (painful urination)	___	___
Hematuria (blood in urine)	___	___
Incontinence	___	___
Frequency of urination	___	___
Vaginal discharge	___	___
Dysmenorrhea (painful menstruation)	___	___
Post-menopausal vaginal bleeding	___	___
Painful intercourse	___	___
Infertility	___	___
Hx of STD	___	___
Date of last period	___	___

Pulmonary System	**Yes**	**No**
Dyspnea (labored breathing)	___	___
Wheezing	___	___
Prolonged cough	___	___
Sputum production	___	___

Amount: ________________________
Color: ________________________

Endocrine System	**Yes**	**No**
Excessive thirst	___	___
Excessive hunger	___	___
Polyuria (large volume of urine)	___	___
Excessive sweating	___	___
Fatigue	___	___
Weakness	___	___
Thyroid problems	___	___

Neurological System	**Yes**	**No**
Ataxia	___	___
Memory lapses	___	___
Confusion	___	___
Head trauma	___	___
Neurological disorder	___	___
Tremors	___	___
Slurred speech patterns	___	___
Hearing/Visual disturbances	___	___

Other Systems	**Yes**	**No**
ENT (ears, nose, throat)	___	___
Integumentary (skin)	___	___
Lymphatic	___	___
Psychiatric	___	___
Musculoskeletal	___	___

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS/HIPPA

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment
A means of communication among the many health professionals who contribute to my care
A source of information for applying my diagnosis and surgical information to my bill
A means by which a third-party payer can verify that services billed were actually provided
A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and will be provided by request a **NOTICE OF PRIVACY PRACTICES** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing except to the extent that the organization has already taken action in reliance thereon.

Signature of Patient/Parent/Guardian: ____