WELCOME TO DECATUR PHYSICAL THERAPY & SPORTS MEDICINE

(Please complete **ALL** information)

TODAY'S DATE: _____

FIRST NAME: _____ M: _____ LAST: _____

STREET ADDRESS: _____

CITY: _____ ST: _____ ZIP CODE: _____

PREFERRED NAME: _____EMAIL: _____

DATE OF BIRTH: _____ GENDER: ☐ M ☐ F ☐ Prefer not to say

EMPLOYER: _____ OCCUPATION: _____

HOME PHONE # _____ OKAY TO CONTACT + LEAVE A MESSAGE? ☐ YES ☐ NO

WORK PHONE # _____ OKAY TO CONTACT + LEAVE A MESSAGE? ☐ YES ☐ NO

CELL PHONE # _____ OKAY TO CONTACT + LEAVE A MESSAGE? ☐ YES ☐ NO

EMERGENCY CONTACT NAME: _____

RELATIONSHIP TO PATIENT: _____ BEST PHONE # _____

REFERRING PHYSICIAN: _____ PHONE: _____

OFFICE LOCATION: _____

I certify that the above information is true and correct to the best of my knowledge. I will notify Decatur Physical Therapy immediately of any changes in my status.

Signature: _____ Date: _____

Responsible Party: (parent, guardian, etc.):_____

Address (if different):_____

INFORMED CONSENT

_____ ***INITIALS.*** **Conditions of, and Consent for Treatment:** I hereby request and authorize Decatur Physical Therapy to perform therapy on me. I understand that I am a patient of Cecil Anderson or Charles Owen. I consent to treatment, which will include evaluation/assessment and treatment.

_____ ***INITIALS.*** **Cooperation with Treatment:** I understand that in order for physical therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home physical therapy program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

_____ ***INITIALS.*** **Financial Acknowledgement:** If you have medical insurance, we will help you get the most out of your insurance benefits. To reach this goal, we need your help.

- Our staff will help you by filing an insurance claim, as payment for your therapist's care.
- We have made every effort to determine if the care you receive here will be covered by your insurance company, to understand the benefit they will pay, and to communicate that clearly to you. We rely on information from you and your insurance company to estimate your financial responsibility. We are not responsible for errors in that information.
- Payment for services is due when you receive treatment, unless payment arrangements have been made.
- All services may not be covered by all insurance contracts. We have made every effort to insure that we only provide services that are covered by your insurance company. If your doctor has ordered services that we know are not covered, we will advise you. You are responsible for charges not covered by your insurance company.
- **We understand financial problems can affect the on-time payment of your account. If this happens, call us at 404-297-9315 for help.**

_____ ***INITIALS.*** **Notice of privacy practices acknowledgement:** Our commitment is to serve our patients with professionalism and caring, always being sure to protect the privacy and security of all Protected Health Information. During the course of your treatment, it may be necessary to share information with our health care providers, insurance companies, billing services, family members and others involved in your case. We are committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law.

- I have read and understand the above notice of Privacy Practices
- I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact you to obtain a current copy of the Notice of Privacy Practices.

I have read the above policies completely. I agree to all the terms and understand that if I violate these policies it may result in the termination of my doctor/patient relationship.

Signature: _____ Date: _____

PATIENT MEDICAL HISTORY & GENERAL HEALTH INFORMATION

NAME: _____

Height: _____Weight: _____ Age: _____

Other than the reason for your visit today, please describe any other orthopaedic or musculoskeletal injuries/problems you are experiencing:

_____

_____

List any other past surgeries + hospitalizations and dates:

_____

_____

Do you have any metal implants (plates, screws, staples)? ☐ YES ☐ NO

Do you have a pacemaker and/or a defibrillator? ☐ YES ☐ NO

Do you smoke cigarettes, a pipe or chew tobacco or vape? ☐ YES ☐ NO

Have you had physical therapy for any problems this year? ☐ YES ☐ NO

If yes, where + when?

_____

Please list all medications you are taking **NOW** (including prescriptions, over-the-counter, vitamins, herbs + natural/homeopathic medicines) with dose + frequency.
(***If you have a list, we can copy it for you***)

_____

_____

_____

_____

_____

_____

Have you ever been diagnosed or treated for any of the following?		
☐ Anemia	☐ Heart Disease/Angina	☐ Recent weight loss/gain
☐ Arthritis ☐OA ☐RA	☐ Hepatitis/Liver Disease	☐ Shortness of breath
☐ Asthma/Emphysema/COPD	☐ HIV Positive	☐ Stroke/TIA
☐ Cancer	☐ Hypertension/High Blood Pressure	☐ Thyroid Problems
☐ Diabetes/Pre-diabetes	☐ Kidney Disease/Infection	☐ Tuberculosis
☐ Epilepsy/Convulsions/Seizures	☐ Osteoporosis	☐ Ulcers/Stomach Problems
☐ Headaches/Migraines	☐ Pregnant Due date:_____	☐ OTHER:

Are there any other medical conditions that your PT should know? If yes, please describe:

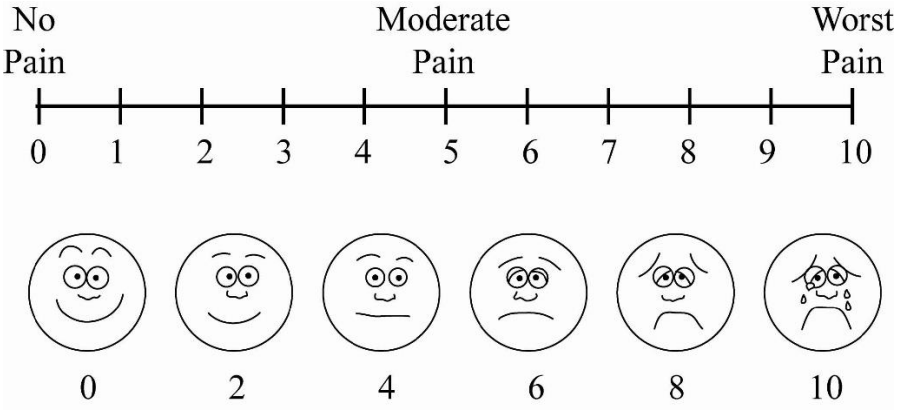
_____

_____

PLEASE RATE YOUR PAIN ON A SCALE FROM ZERO TO TEN.

'***ZERO***' means you have *NO PAIN* at all. ***'TEN'*** means the *WORST* possible pain you can imagine.

Please circle the number you would give to your pain:



FALLS RISK ASSESSMENT

- Are you 65 years old or older? ☐ YES ☐ NO
- Have you fallen in the last 12 months? ☐ YES ☐ NO
- If the answer is yes, how many falls? _____
- Was there an injury with a fall? ☐ YES ☐ NO

I certify that the above information is true and correct to the best of my knowledge. I will notify Decatur Physical Therapy immediately of any changes in my status.

Signature: _____ Date: _____