Appointment Date: _____Time: _____

DIRECT PHYSICAL THERAPY, LLP

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Age: _____
(First, Middle, Last)

Mailing Address: _____City: _____ State: ____ Zip Code: _____

Phone #: _____Email: _____

Cell #:_____ Sex: M F Marital Status: S M W D

Emergency Contact: _____ Phone #: _____

Please complete the following insurance information

<u>Bring your photo id and insurance card(s)</u> to your visit

Primary Insurance Company: _____Subscriber/Member #:_____

Is your insurance through a spouse, parent or other responsible party? Yes No

If yes: Responsible parties name: _____DOB: _____

Do you have a Copay: Yes No Amount of Copay $: _____

Do you have a Deductible: Yes No Amount of Deductible $: _____

Has your Deductible been met: Yes No Amount Remaining $: _____

Do you have a physical therapy visit limit: Yes No Number of visits used this year:_____

Is an authorization required: Yes No

Do you have a secondary insurance: Yes No

Name of Company: _____

By signing below, I acknowledge Direct Physical Therapy, LLC is not responsible for checking my insurance benefits and it is my responsibility to inquire about eligibility and/or authorization:

Patient Signature: _____ Date: _____

Consent Form

1. Consent for treatment: I understand that my Physical Therapy treatment is under the direction of my physician. I give my consent for treatment by the Healthcare Professional Staff at Direct Physical Therapy, LLC and necessary treatment as prescribed by my physician or deemed appropriate by the rendering Physical Therapist. I understand that to evaluate and treat my condition, the physical therapy staff must have visual or physical access to areas of my body which may be experiencing and/or causing my pain and/or dysfunction. I understand it is my responsibility to immediately communicate any difficulties or concerns I may have regarding my therapy to the staff at Direct Physical Therapy, LLC. I further understand that my physician will be kept informed regarding my current health status and response to any treatment received. As with any course of treatment or therapy, there is always the possibility of an unexpected complication and no guarantee or assurance has been made as to result of treatment.

2. Financial Agreement: I agree to pay all charges for treatment at their regular rates and terms. If the account is referred to an attorney or agency for collection, or if suit or other action is instituted in connection with any controversy arising out of this agreement, the prevailing party shall be entitled to recover reasonable attorney fees at trial, arbitration, and on appeal.

3. Insurance Requirements: I understand that it is my responsibility to obtain services under the terms and conditions of my insurance policy. Services obtained outside the terms and conditions of my policy are my financial responsibility. Direct Physical Therapy, LLC will not be liable for charges not paid by my insurance.

4. Assignment of Benefit and Proceeds: I assign Direct Physical Therapy, LLC all benefits available under any insurance coverage, workers compensation, governmental agency, and disability benefits, in full amount of all charges. I am responsible for any uncovered or unpaid balance owing regardless of the assignment. This assignment may only be revoked in writing, and cannot be revoked if Direct Physical Therapy, LLC has taken action in reliance.

5. Patient's Certification, Authorization to Release Information and Payment Request: If my insurance is Medicare, I certify that the information given by me in applying for payment under title XVIII of the social security act (Medicare) is correct. I authorize any holders of medical or other information about me to release to the social security administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

By signing below, I agree to the terms and conditions of this consent form:

Date: _____ Patient/Guardian Signature: _____

Date: _____ Therapist/Office Staff Signature: _____

Acknowledgement of Receipt of Privacy Practices

By signing this form, you acknowledge that you have been offered a copy for review of Direct Physical Therapy, LLC's Notice of Privacy Practices, which is displayed in the clinic. This Notice of Privacy Practices provides information about how we may use and disclose your protected health information. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice and if you have any questions about our Notice of Privacy Practices, please call Direct Physical Therapy, LLC at (541) 941-5170.

Date: _____ Patient/Guardian Signature: _____

New Client Health History Form

DIRECT PHYSICAL THERAPY, LLP

Name:_____ **Date:** _____

Date of Birth: _____ **Age:** _____ **Hand Dominance:** ❑**Right** ❑**Left**

Occupation, including activities that comprise your workday:_____
Leisure activities, including exercise routines:_____

Living Situation (check all that apply): ❑live alone ❑live with family members/others ❑live with caregiver
❑home/apartment ❑assisted living complex ❑retirement complex (SNF/ICF) ❑other _____

How would you rate your general health? ❑Excellent ❑Good ❑Fair ❑Poor

Do you smoke? ❑**Yes** ❑**No** **Do you have a pacemaker or other internal device?** ❑**Yes** ❑**No** _____

FOR WOMEN: Are you currently pregnant or think you might be pregnant? ❑**Yes** ❑**No**

ALLERGIES: List any medications or materials you are allergic to: _____
Are you latex sensitive? ❑**Yes** ❑**No**

Have you RECENTLY noted any of the following (check all that apply)?

❑ fatigue	❑ falls	❑ headaches
❑ fever/chills/sweats	❑ numbness or tingling	❑ nausea/vomiting
❑ changes in bowel/bladder function	❑ muscle weakness	❑ difficulty swallowing
❑ weight loss/gain	❑ dizziness/lightheadedness	❑ shortness of breath
❑ difficulty maintaining balance while walking	❑ fainting	❑ cough

❑ other _____

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

❑ cancer _____	❑ bone/joint problems (arthritis) _____
❑ heart problems _____	❑ neurological problems (stroke, MS) _____
❑ lung/breathing problems _____	❑ chemical dependency _____
❑ circulation problems _____	❑ depression
❑ eye/vision prolems _____	❑ diabetes
❑ kidney/bladder problems _____	❑ high cholesterol
❑ liver problems _____	❑ high blood pressure
❑ thyroid problems _____	❑ osteoporosis

❑ other _____

Please list surgeries/dates:

_____/_____ _____/_____ _____/_____ _____/_____

Please list medications/dosage (please provide medication list, if possible):

_____/_____ _____/_____ _____/_____ _____/_____

_____/_____ _____/_____ _____/_____ _____/_____

_____/_____ _____/_____ _____/_____ _____/_____

Have you ever taken steroid medications for any medical conditions? ❑**YES** ❑**NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? ❑**YES** ❑**NO**

Have you fallen in the last year? ❑**YES** ❑**NO**
If yes, how many times in the last year?_____
If you have fallen in the last year, were you injured? ❑**YES** ❑**NO** If yes, please explain_____
_____

What date (roughly) did your present problem(s) start?_____ _____

Did your problem(s) occur: ❑at work ❑during a motor vehicle accident ❑other_____

Are you on a work restriction from your doctor? ❑Yes ❑No

What do you think caused your problem(s)? _____

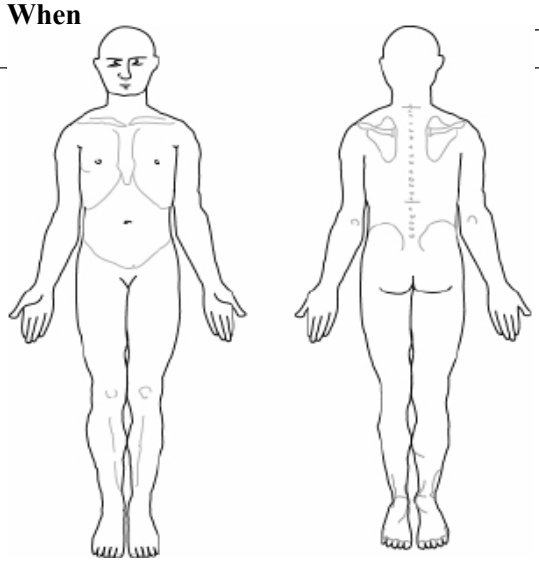
My symptoms are currently: ❑ getting better ❑ getting worse ❑ staying about the same

Treatment received so far for this problem (chiropractic, injections, etc) _____
Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

Have you ever had this problem before: ❑**Yes** ❑**No** **When** _____
Treatment received_____ _____

Body Chart:

Please mark the areas where you
feel symptoms on the chart to the right with
the following symbols to describe your symptoms:



↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**

My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change intensity during activity

When are your symptoms the worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After activity
When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After activity

Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:
Your current level of pain while completing this survey: _____
The best your pain has been during the past 24 hours: _____
The worst your pain has been during the past 24 hours: _____

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:
_____
_____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:
_____
_____

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication