QUANTUM

Physical Therapeutics

Patient Registration

Name: _____ Date:_____

Date of Birth:_____ Email:_____

Address:_____

Cell Phone:_____ Work:_____ Home Phone:_____

Employer:_____ Occupation:_____

Emergency Contact:_____ Relationship to Person:_____

Referring Medical Practitioner:_____

How did hear about QPT:_____

Quantum Physical Therapeutics does not participate with any insurance companies and is not a Medicare Provider. Patients are required to pay at the time of service. Should you choose to submit to your insurance for reimbursement, QPT as a courtesy may give you a receipt with treatment codes to facilitate your own submission. QPT cannot be responsible should your insurance company decide not to reimburse you. Please understand your out-of-network medical coverage and prescription requirements. If you choose to submit to your insurance, you will need to provide a physician prescription for physical therapy that reads "Physical therapy evaluate and treat" along with up to four ICD 10 diagnosis codes. I understand that a physical therapist diagnosis is not a medical diagnosis from a physician.

Patient Signature:_____ Date:_____

Medical History Disclosure Form

Name:_____ Age:_____

What areas of the body (i.e. neck, left hip, right knee, etc) or conditions (i.e. fibromyalgia, osteoarthritis, etc) are you currently seeking physical therapy for? If there are multiple areas, which one is of greatest concern?

Have you've ever been treated for the same problem before? When, what, where and by who"? Did prior treatment successfully manage or resolve the problem at that time?

Please circle any/all illness you've had in the past or currently have:

Cardiovascular disease	Asthma/Breathing Difficulty	Hepatitis/Liver Disease
Depression	High Blood Pressure	Congestive Heart Failure
Anemia	Diabetes (I or II)	Epilepsy/Seizures
Thyroid Condition	Osteoporosis	Multiple Sclerosis
Fibromyalgia	Neurological Condition	Stoke/Heart Attack
Arthritis (osteo/rheum)	Migraines/Headache	Chronic Infections
Lupus	Kidney/Renal Disease	Eating Disorder
Drug or Alcohol Abuse	HIV/AIDS	Dizziness/Vertigo

Cancer (type)_____ Location(s) _____ Year_____
Status_____
Other:

Do you have any implanted medical device?

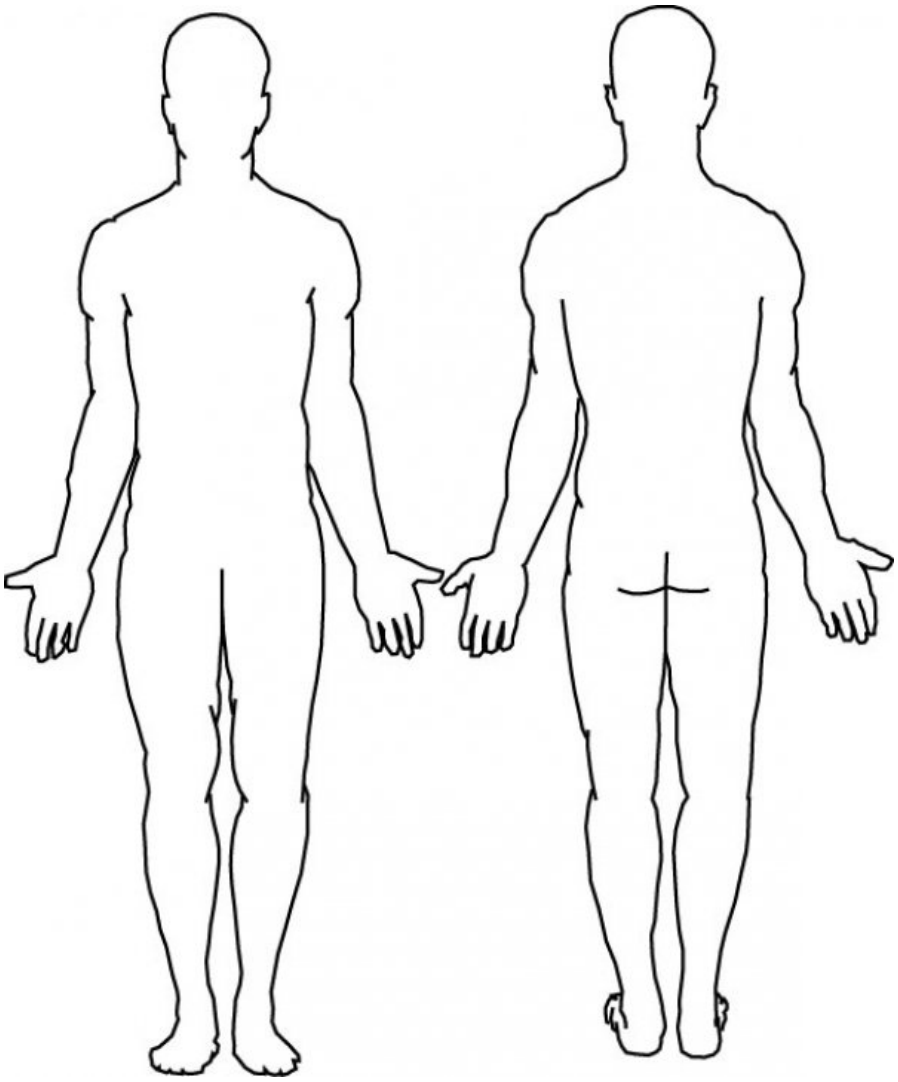
Please list all prescription medications you are currently taking and reason for the medication (i.e. Prozac for depression, Percocet for pain, Accupril for high blood pressure).

Are you currently pregnant or is there a possibility that you may be pregnant?

I CERTIFY TO THE BEST OF MY KNOWLEDGE THAT THE ABOVE INFORMATION IS COMPLETE AND TRUE. IF MY MEDICAL/HEALTH STATUS CHANGES, I WILL INFORM MY THERAPIST IMMEDIATELY.

Signature:_____ Date:_____

Please mark the drawings with the following letters to indicate areas of pain (P), numbness (N), tingling (T), or weakness (W).



Please rate your pain using this scale. Also, please indicate which areas of your body the scores apply to. (0 = no pain), (10 = emergency room pain).

0 10

Consent to Treat

I, _____, give Kelly Born and QPT Therapists permission to evaluate me for a physical therapy condition and provide treatment which will include manual therapy, therapeutic exercise, movement, neuromuscular reeducation, patient education, and/or other modalities deemed necessary by the therapist for promotion of healing, health and wellness. I understand the treatment I am provided is with the professional discretion of my Physical Therapist. I understand I have a right to refuse, disallow, or ask for modifications and I agree to verbally communicate such. I agree to verbally share with my therapist if I need further explanation of the treatment or if I am unable to fully participate with assignments given by my Physical Therapist. I understand that to fully benefit from the treatment provided I will have to participate on my own behalf outside of my treatment sessions. This might include home exercises, posture modification, self-myofascial treatment, or anything else my therapist suggests for me to do to progress my therapeutic process.

I understand that response to Physical therapy and myofascial release varies from person to person; hence it is not possible to accurately predict your response to specific interventions. QPT does not guarantee what my reaction will be, nor does it guarantee that treatment will resolve the condition for which I am seeking help. Furthermore, it is possible that therapy will temporarily aggravate existing symptoms; however, this is not injurious.

It is very important to communicate

In order for my therapist to most effectively treat me with manual therapy, I may be asked to remove some clothing or wear little clothing during treatment. I understand that if I am uncomfortable with this, I will share my concerns with my therapist and my request will be accommodated.

I understand that a physical therapy diagnosis is not a medical diagnosis from a physician and that my therapist will refer me to an appropriate licensed healthcare provider if medically indicated.

Patient Signature:_____ Date:_____