19 North Main Street, Suite 1A
Sherborn, MA , 01770
p. 508. 545. 2352 f. 508. 545. 2354

PLEASE PRINT CLEARLY AND COMPLETE ALL ITEMS FOR PROPER PROCESSING OF YOUR CLAIM

SEC 1

NAME _____ _____ _____ ☐ She/Her ☐ He/Him ☐ They/Them
FIRST MIDDLE LAST PREFERRED GENDER PRONOUN

ADDRESS _____
STREET APT.# CITY STATE ZIP

PHONE _____ MOBILE _____ D.O.B. _____

EMAIL _____

EMERGENCY CONTACT _____ PHONE _____

SEC 2 ***HOW DID YOU HEAR ABOUT US?***

☐ MD REFERRED _____ ☐ MD REFERRAL LIST ☐ INSURANCE CO. WEBSITE
PHYSICAN'S NAME

☐ SIGN/DRIVING BY ☐ FORMER PATIENT _____
PATIENT NAME

☐ FACE BOOK/ NEXT DOOR ☐ INTERNET SEARCH ENGINE (GOOGLE, YELP)

SEC 3 ***HEALTH COVERAGE***

PRIMARY INSURANCE _____ PCP _____
(NAME) (PRIMARY CARE PHYSICIAN)

SUBSCRIBER _____ PCP TOWN _____

SEC 4 ***TYPE OF INJURY***

IS THIS INJURY RELATED TO AN ACCIDENT AT WORK? OR AN AUTO ACCIDENT? ☐ YES ☐ NO

PROTECTED HEALTH INFORMATION CONTACT CONSENT

I CONSENT TO RECEIVE APPOINTMENT REMINDERS VIA TEXT AND EMAIL, AND OTHER HEALTHCARE COMMUNICATIONS/ INFORMTION AT THE EMAIL ADDRESS AND/OR PHONE NUMBERS PROVIDED ABOVE _____ PATIENT INITIALS

SEC 5 ***CONSENT FOR TREATMENT***

I THE UNDERSIGNED, A PATIENT OF BACK TO YOU PHYSICAL THERAPY & SPORTS MEDICINE INC., DO HEREBY CONSENT TO TREATMENT AS PRESCRIBED BY MY PROVIDER, A LICENSED PHYSICAL THERAPIST IN THE STATE OF MASSACHUSETTS.

I HAVE READ AND UNDERSTAND THE CONSENT FOR TREATMENT _____ PATIENT INITIALS

SEC 6 ***HIPAA NOTICE OF PRIVACY PRACTICES***

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF OUR PATIENTS, AND PROVIDE INDIVIDUALS WITH A NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION. YOUR SIGNATURE BELOW IS TO ACKNOWLEDGE THAT YOU HAVE BEEN GIVEN A NOTICE OF OUR PRIVACY PRACTICES.

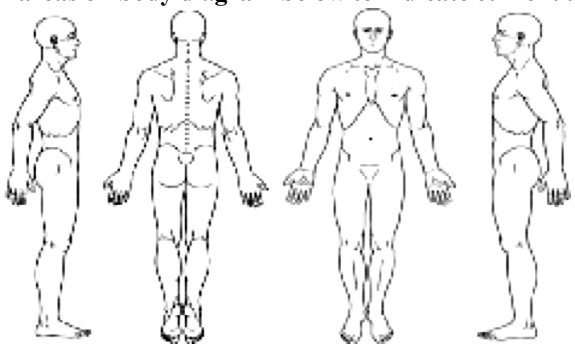
_____ _____
PATIENT SIGNATURE DATE

Back to You
Physical Therapy & Sports Medicine

PATIENT HEALTH QUESTIONNAIRE

Name:_____ Date of Birth:_____Age:_____Right / Left Hand dominant

Please shade in areas on body diagram below to indicate current areas of pain:



What is the reason for your visit? _____

Have you had Physical Therapy in last 12 months? **YES** or **NO** How many visits? _____

Have you had Home Care? **YES** or **NO** If YES, what was Discharge date ___/___/____

Are your symptoms: □ Improving □ Getting Worse (Evolving and/or Changing) □ Staying the Same □ My pain is different depending on the activities □ My pain (fluctuates in intensity and duration, is unpredictable)

Height _____ Weight _____

Have you had x-rays, MRIs, or other special tests performed for your current problem? **Yes / No** Please give dates and results.

_____

_____

Are you currently pregnant? **Y / N** Do you have allergies/**latex sensitivity**? _____

Medical History (check conditions that may apply)

___ Arthritis
___ Broken bones/fractures
___ Osteoporosis
___ Circulation/vascular problems
___ Heart Problems
___ High blood pressure
___ Pacemaker/Defibrillator
___ Stroke
___ Diabetes
___ Headaches
___ Lung problems
___ Other:_____

___ Low blood sugar/hypoglycemia
___ Head injury
___ Multiple Sclerosis
___ Bowel or Bladder problems
___ Parkinson's Disease
___ Seizure/epilepsy
___ Developmental/growth problems
___ Thyroid problems
___ Dizziness
___ Cancer (type) _____

___ Tuberculosis
___ Hepatitis, HIV+, infectious disease
___ Shortness of breath/chest pains
___ Unexplained weight loss/gain
___ Ulcers/stomach problems
___ Vision problems
___ hearing problems
___ Balance problems, history of falls
___ Nausea/vomiting
___ Depression

List all past surgeries (month/year)_____

_____

List all medications you are currently taking_____

_____

_____

_____

Patient Signature:_____**Date:**_____

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Back to You
Physical Therapy & Sports Medicine

COVID-19 CONSENT FORM

Date: _____

Patient Name:_____ DOB: _____

- ☐ I understand that I am receiving Physical Therapy during the events of a Covid-19 National Emergency.
- ☐ I understand that there may be a risk in being in proximity of Physical Therapists, patients, or staff.
- ☐ I understand that Back to You Physical Therapy is taking precautions to limit the spread of the disease, yet there is still a possibility of transmission.
- ☐ I agree not to hold my treating Physical Therapist, or any employees working for Back to You Physical Therapy and Sports Medicine Inc. liable for my actions, or liable for any negative results or symptoms that can develop due to treatment.
- ☐ I understand that I may reconsider my decision at any time.

Patient Signature: _____

Printed Name: _____

I consent to treatment during the Covid-19 Emergency.

By checking this box, I am certifying that I have discussed my care options with my physical therapist, including the option of telehealth physical therapy, and I am choosing to participate with "in clinic" care. By my signature below, I attest that I have been made aware of the options available and have determined that in-clinic physical therapy is essential to my best results. I personally and solely accept the associated risk of disease transmission and potential consequence.

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