TAYLOR PHYSICAL THERAPY ASSOCIATES, LLC

80 Amhearst Blvd., Ste. 300 Nashua, IA 50658 Phone: (641) 435-4476 Fax: (641) 435-4491

_____New Patient _____ Established Patient **Patient Medical History**

Name: ______________________ **Birth Date:** ____________ **Age:** __________

Home Address: ______________________ **City:** __________ **State:** ______ **Zip:** ______

Where Employed: ______________________________

Spouse's Name: ______________________ **Employer:** ______________________

Home Phone: ______________ **Work Phone:** ______________ **Cell Phone:** ______________

Email Address: ______________________ **May we contact you by email?** _____ **Yes** _____ **No**

Emergency Contact Person: ______________________ **Phone:** ______________

Have you been treated by a physical, occupational, speech therapist, or chiropractor at any facility within this calendar year? _____ **Yes** _____ **No** **If so, number of visits:** __________

Who is your insurance provider? ______________________________

Are you currently being seen by a Home Health Agency? _____ **Name of Agency** ______________________

Brief description of injury or illness ______________________________

____

______________________________ **Date symptoms started** ______________

Is your injury: Work related? _____ **Yes** _____ **No** **Motor vehicle accident?** _____ **Yes** _____ **No**

What are your goals for therapy? ______________________________

____

Do you have or have you had any of the following?

___ Heart Problems
___ Pacemaker
___ High/Low Blood Pressure
___ Circulatory Problems
___ COPD/Emphysema
___ Asthma
___ Shortness of Breath
___ Chronic Ulcer
___ Anemia
___ History of Smoking
___ Diabetes
___ Kidney Disease
___ Cancer
___ Hepatitis
___ Tuberculosis
___ Rheumatic Fever
___ Multiple Sclerosis
___ Blood Clots
___ Back Pain/Sciatica
___ Osteoporosis
___ Artificial Joints/Implants
___ Seizures
___ Dizziness/Vertigo
___ Depression/Mental Illness
___ Stroke
___ Hearing/Visual Difficulties
___ Rheumatoid Arthritis
___ Other Arthritis
___ Dementia
___ Currently or Possibly Pregnant

List any other medical information or special test you've completed that you believe would be beneficial for us to be aware of : ______________________________

____

____

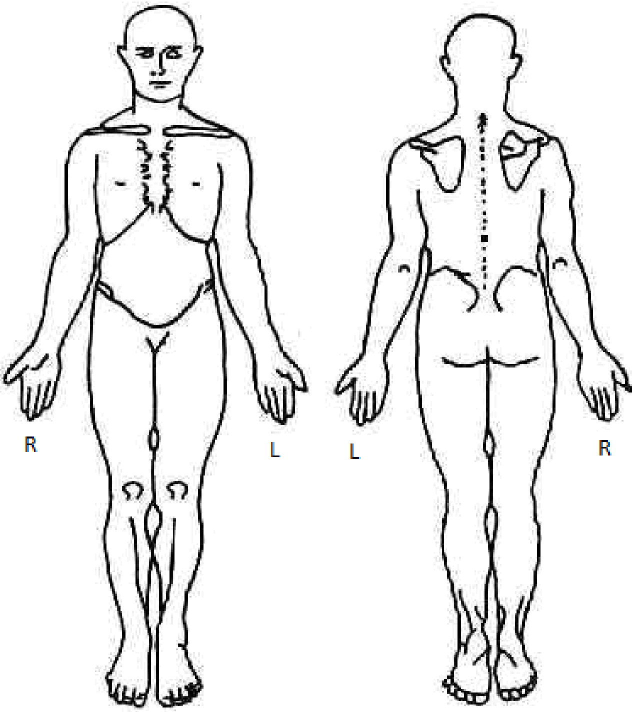
Current Medications: ______________________________

____

Height ________ **Weight** ________

(Please fill out back page)

Mark on the diagram below where you Are currently experiencing symptoms



Mark below the intensity of your symptoms.
Please circle the appropriate number)

0= no symptoms, 10= worst possible symptoms

Currently: 0 1 2 3 4 5 6 7 8 9 10
At its best: 0 1 2 3 4 5 6 7 8 9 10
At its worst: 0 1 2 3 4 5 6 7 8 9 10

How restricted are you in your normal activities?
(0 = No Limitations; 10 = Totally Disabled)

0 1 2 3 4 5 6 7 8 9 10

Work capabilities since your injury:

____ No Work Limitations
____ Some Work Limitations
____ Unable to Work
____ N/A (Child, Student, Retiree, Disabled)

How often do you have these symptoms?
(Please check one below)

_______**Constantly (24 hours/day)**
_______**Occasionally (6-12 hours/day)**
_______ **Frequently (12-23 hours/day)**
_______ **Not frequently (0-6 hours/day)**

Please list other treatment you have received for this condition

____

____

How did you hear about Taylor Physical Therapy? ______________________________

____

____

INFORMED CONSENT

I hereby authorize treatment to be administered after evaluation according to the therapist's discretion. This may include, but not limited to, spinal or joint traction, ultrasound, electrical muscle stimulation, whirlpool or aquatic therapy, iontophoresis, manual therapy, instrument assisted soft tissue mobilization, and exercises. I understand that the necessary procedures to be provided will be explained along with the risks and benefits. We utilize a therapy dog in our clinic so please let us know if you have a known allergy.

Patient's Signature____ Date ____________________

TAYLOR PHYSICAL & OCCUPATIONAL THERAPY

Acknowledgement of Receipt of Notice of Privacy Practices

The Notice of Privacy practices the types of uses and disclosures of your protected health information that might occur in my treatment, payment of my bills or in the performance of Taylor Physical Therapy and Associates, LLC health care operations. The Notice of Privacy Practices also describes my rights and Taylor Physical Therapy Associates, LLC duties with respect to my protected health information. I understand that the Notice of Privacy Practices is posted in the physcial therapy clinic for my review and that I can request my own copy if so desired.

Taylor Physical Therapy and Associates, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

Assignment of Insurance Benefits/Financial Agreement

I authorize payment of my insurance benefits directly to Taylor Physical Therapy and Associates, LLC for services provided. I understand that I am financially responsible to pay the usual charges for PT/OT services, whether they are covered by my insurance or not, including any balance not covered by my insurance carrier.

Release of Information

I authorize the release of any medical or other information to process this claim. Taylor Physical Therapy and Associates, LLC may disclose all or part of my medical record to any person or corporation which may be liable under a contract to Taylor Physical Therapy Associates, LLC, myself, a family member, or my emlopyer for all or part of the charge for services. I authorize the release of information about my health status for continuing healthcare services and to the referring physician.

My signature represents that I have read and understand the terms and statements above in regards to the notice of privacy, the financial agreement, and release of information. This authorization is in effect form the signature date unless revoke by me in writing.

Patient Signature ____ Date _________________________

Signature of Personal

Representative____ Date _________________________

Description of Personal Representative's Authority____

Patient did not sign for the following reason: ☐ Minor ☐ Physically Unable ☐ Has Legal Guardian

I have witnessed the completion of this authorization form.

____

Employee Signature Date