



TAYLOR

PHYSICAL THERAPY

Name _____ Birth Date _____ Age _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email address _____ May we contact you by email? Yes No

Where Employed _____ Work Phone _____

Spouse's Name _____ Employer _____

Emergency Contact Person _____ Phone _____

Who is your insurance provider? _____

Are you currently being seen by a Home Health Agency? _____

Name of Agency _____

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 _____

Is your injury: Work related? ___Yes ___No Motor vehicle accident? ___Yes ___No

Date symptoms started _____

Brief description of injury or illness _____

What are your goals for therapy? _____

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Dizziness/Vertigo |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hearing Difficulties |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Neurologic Conditions | <input type="checkbox"/> Visual Difficulties |
| <input type="checkbox"/> History of Smoking | <input type="checkbox"/> Blood Thinner | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Other Arthritic Conditions |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Back pain/sciatica | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Artificial Joints/Implants | <input type="checkbox"/> Currently or possibly pregnant |

Fall History: Number of Falls within the last year ___1 ___2 ___2+

Did a fall result in injury? ___Yes ___No

Special Tests: ___X-ray ___Bone Scan ___CT Scan ___MRI

List any prior surgeries: _____

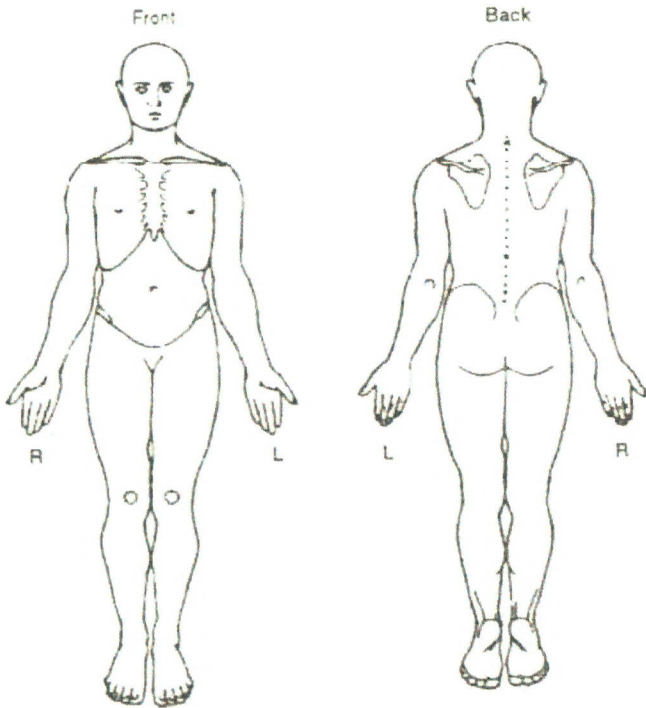
Current Medications _____

(Please fill out back page)

Height _____ Weight _____

PATIENT MEDICAL HISTORY

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, tapping techniques, ultrasound, electrical muscle stimulation, whirlpool or aquatic therapy, iontophoresis, manual therapy, instrument assisted soft tissue mobilization, and exercises. I hereby consent and authorize Taylor Physical Therapy to utilize my picture for our medical records. I understand that the necessary procedures to be provided will be explained along with the risks and benefits.

Patient's Signature _____ Date _____

TAYLOR PHYSICAL & OCCUPATIONAL THERAPY

Acknowledgment of Receipt of Notice of Privacy Practices

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

Taylor Physical Therapy and Associates 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 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 Associates, myself, a family member, or my employer for all or part of the charge for services. I authorize the release of information about my health status for continuing health care 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 from the signature date unless revoked 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