

TAYLOR PHYSICAL THERAPY ASSOCIATES, LLC

1306 Hwy 57, Ste. B Parkersburg, IA 50665

Phone: (319) 346-9783 Fax: (319) 346-9785

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

Diabetes

Artificial Joints/Implants

Pacemaker

Kidney Disease

Seizures

High/Low Blood Pressure

Cancer

Dizziness/Vertigo

Circulatory Problems

Hepatitis

Depression/Mental Illness

COPD/Emphysema

Tuberculosis

Stroke

Asthma

Rheumatic Fever

Hearing/Visual Difficulties

Shortness of Breath

Multiple Sclerosis

Rheumatoid Arthritis

Chronic Ulcer

Blood Clots

Other Arthritis

Anemia

Back Pain/Sciatica

Dementia

History of Smoking

Osteoporosis

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

PATIENT MEDICAL HISTORY

Mark below the intensity of your symptoms.

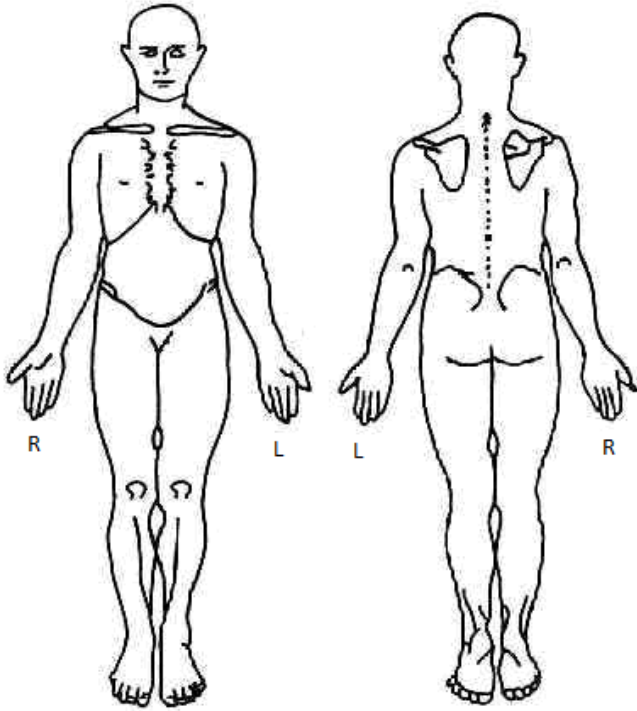
Please circle the appropriate number)

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 physical 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 employer 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 from 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