

# TAYLOR PHYSICAL & OCCUPATIONAL THERAPY ASSOCIATES, LLC

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Phone: (563) 578-5125 Fax: (563) 578-5276

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?

- |                                                  |                                             |                                                         |
|--------------------------------------------------|---------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Heart Problems          | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Artificial Joints/Implants     |
| <input type="checkbox"/> Pacemaker               | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Seizures                       |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Dizziness/Vertigo              |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Depression/Mental Illness      |
| <input type="checkbox"/> COPD/Emphysema          | <input type="checkbox"/> Tuberculosis       | <input type="checkbox"/> Stroke                         |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Rheumatic Fever    | <input type="checkbox"/> Hearing/Visual Difficulties    |
| <input type="checkbox"/> Shortness of Breath     | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Rheumatoid Arthritis           |
| <input type="checkbox"/> Chronic Ulcer           | <input type="checkbox"/> Blood Clots        | <input type="checkbox"/> Other Arthritis                |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Back Pain/Sciatica | <input type="checkbox"/> Dementia                       |
| <input type="checkbox"/> History of Smoking      | <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> 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: \_\_\_\_\_

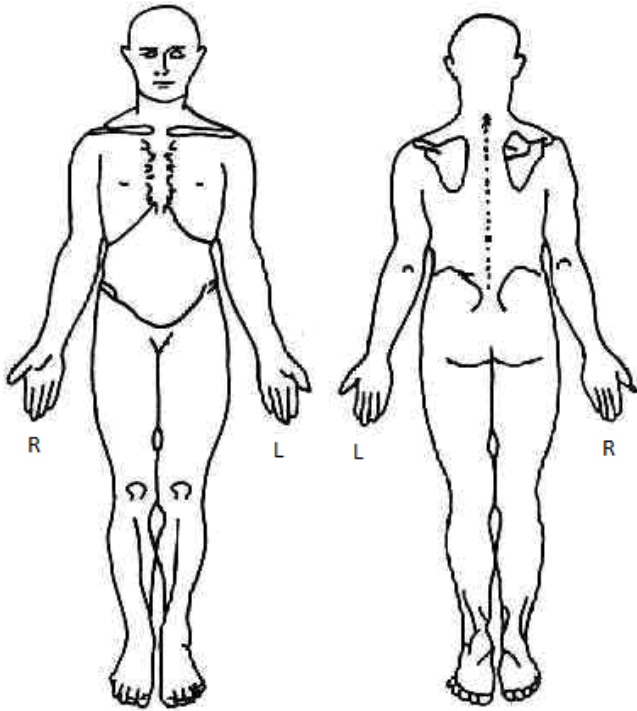
Current Medications: \_\_\_\_\_

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

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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

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How did you hear about Taylor Physical Therapy? \_\_\_\_\_

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## 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