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?

___Heart Problems
___Pacemaker
___High/Low Blood Pressure
___Circulatory Problems
___COPD/Emphysema
___Asthma
___History of Smoking
___Fibromyalgia
___Anemia
___Osteoporosis
___Diabetes
___Kidney Disease
___Cancer
___Hepatitis
___Stroke
___Neurologic Conditions
___Blood Thinner
___Blood Clots
___Back pain/sciatica
___Artificial Joints/Implants
___Seizures
___Dizziness/Vertigo
___Depression
___Mental Illness
___Hearing Difficulties
___Visual Difficulties
___Rheumatoid Arthritis
___Other Arthritic Conditions
___Dementia
___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: _____

_____

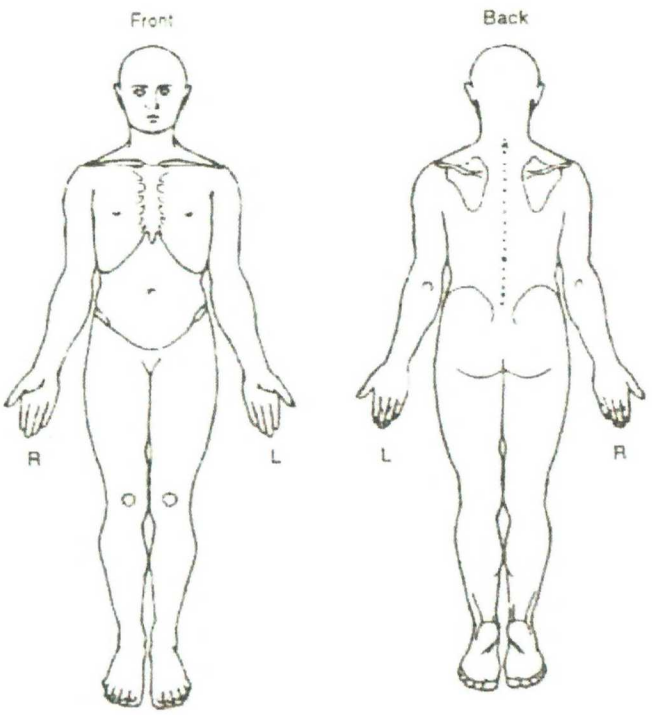
Current Medications _____

_____

(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