TAYLOR PHYSICAL & OCCUPATIONAL THERAPY ASSOCIATES, LLC

1014 West 1St. Street, Sumner, IA 50674 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?

___ 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	___ Osteoporsis	___ 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 : _____

_____

_____

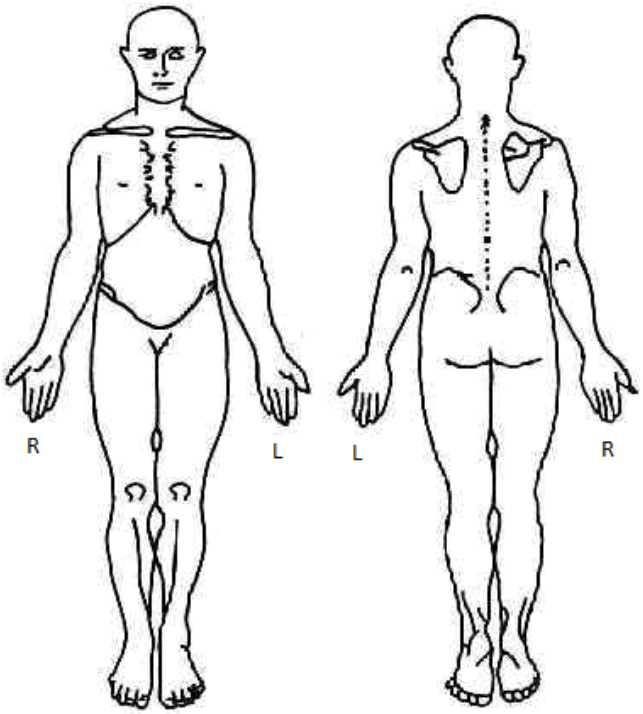
Current Medications: _____

_____

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 out clinic so please let us know if you have a known allergy.

Patient's Signature_____ Date _____

TAYLOR PHYSICAL & OCCUPATIONAL THERAPY

Acknowledgement of Receipt of Noitice of Privacy Practices

The Notice of Privacy practices the types of uses and disclosures of y protected health information that might occur in my treatment, payment of my bills or in the perormance of Taylor Physical Therapy and Associates' health care operations. The Notice of Privacy Practices also describes my rights and Taylor Associates' 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 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 Thearpy and Associates, LLC for services proveided. 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 Thearpy and Associats, 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 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