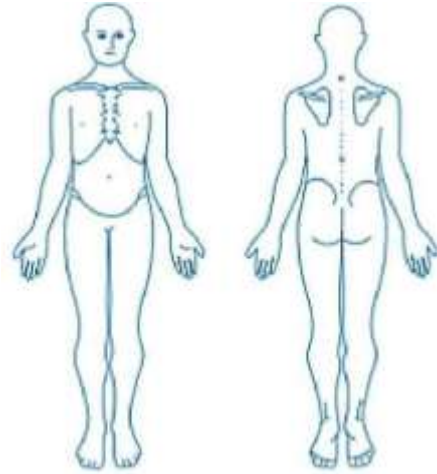


Name: _____ Occupation or previous occupation: _____
 Height: ___ ft ___ in Weight: _____ lbs Age: _____

Area(s) of Injury

Using the drawing on the right:

- **Shade in** all areas experiencing symptoms (pain, stiffness, aches, etc...) on the drawing below.
- **Label** the spot of the worst pain with a small X
- **Circle** any areas of numbness or tingling



1. When did your injury occur? ___ / ___ / ___
2. If post-op, when was your surgery? ___ / ___ / ___
3. Pain level:
 - Current Pain Level ___ / 10
 - Highest Pain Level ___ / 10
 - Lowest Pain Level ___ / 10

Medical Questions - (circle yes/no):

1. **Yes / No** Do you have a pacemaker?
2. **Yes / No** Have you experienced significant weight loss recently?
3. **Yes / No** Have you ever had cancer?
4. **Yes / No** Have you had multiple cortisone or prednisone injections?
5. **Yes / No** Are you taking any anti-inflammatory medications?
6. **Yes / No** Are you taking any muscle relaxants for this problem?
7. **Yes / No** Are you taking any pain medications for this problem?
8. **Yes / No** Are you currently taking any other medications?
 - a. Please list in chart
9. **Yes / No** Do you have any difficulties with urination?
 - a. If YES, please explain

Medication	Dosage	Frequency

10. Have you had any of the following for this specific problem (circle yes/no):
 - Yes / No** CT Scan **Yes / No** MRI **Yes / No** X-Ray

Is there any condition that you feel may affect your treatment in any way? (please circle): heart condition, lung condition, osteoporosis, joint replacements, balance deficit, visual impairment, previous surgeries, skin sensitivity, allergies, dizziness, fainting. Please explain: _____

I acknowledge that the above information I have written is true and accurate to the best of my knowledge. I will notify my therapist of any change in condition.

Patient Signature _____ Date: _____

Office Use:	F x D: _____ x _____ Pre-auth: Y / N	Max visits: _____ Keet: Y / N
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PATIENT INFORMATION

LAST _____ FIRST _____ MI _____
GENDER: M / F DOB: ___MO./___DAY/___YEAR SS# _____ - _____ - _____ MARITAL STATUS _____
PHONE (CELL) _____ PHONE (HOME) _____
EMAIL _____
ADDRESS _____ CITY _____ ST _____ ZIP _____
EMPLOYER _____ ADDRESS _____
OCCUPATION _____ WORK PHONE _____ EXT _____
WHO IS YOUR PRIMARY CARE PHYSICIAN? _____

EMERGENCY CONTACT

LAST _____ FIRST _____ RELATIONSHIP _____
PHONE (CELL) _____ PHONE (HOME) _____

APPOINTMENT REMINDER

Select **one** option below and initial

EMAIL REMINDER _____

TEXT MESSAGE REMINDER: (Select Carrier) _____

ALLTel Boost Cricket MetroPCS Qwest T-Mobile Verizon
 AT&T Cingular Metrocall Nextel Sprint US Cellular Virgin Mobile

NO REMINDER _____

Email/Cell Phone # (If different from above): _____

*Initialing indicates consent for Southland Physical Therapy to provide automatic appointment reminders via the selected method of delivery. I understand that text messaging rates may apply.

REFERRAL SOURCE

WHO MAY WE THANK FOR REFERRING YOU? _____

- Client Community Event Friend Insurance Online Print Media
 Referring MD Return Patient Self Staff Walk-in Yelp



Patient Commitment & Missed Appointment Policy (Cancellation / No Show / Late - Policy)

Our Commitment to You

At Southland Physical Therapy our mission is to demonstrate integrity and compassion while providing the utmost quality in physical therapy care so that each individual, their families, and the community may be able to live happy and well.

Your Commitment to Physical Therapy

Every patient comes to therapy with unique circumstances and needs. Each individual's treatment is personalized by your therapist by creating a specific plan to meet those goals and needs. In order to meet these goals, it is vital you attend all scheduled appointments.

24-Hour Cancellation Policy

A 24-hour notice is required for an appointment to be rescheduled. If you need to reschedule, please call our office to arrange for a make-up appointment in the same week of the original appointment.

Please initial:

_____ We ask for a 24 hour notice for any appointment cancellation. If you call to cancel your appointment after this time you will be subject to a \$40 fee.

_____ No show appointments will be charged a \$40 fee.

_____ Southland Physical Therapy reserves the right to cancel your appointment if you are 15 or more minutes late.

I have read and understand the patient financial responsibility & appointment policy and I agree to adhere to its terms. Altering this form in any way will not change the policy as outlined above by Southland Physical Therapy.

Patient Name (or Responsible Party)

Signature

Date



PATIENT CONSENT

I consent to any medical treatment rendered under the general and special instructions of the physician and/or physical therapist.

I understand that therapeutic procedures can include, but are not limited to: joint and soft tissue mobilization, home exercise programs, therapeutic exercises, neuromuscular education, gait training, functional training including: posture and body mechanics, modalities, such as heat, ice, electrical stimulation, ultrasound, laser, and special procedures such as: taping, neuromuscular electrical stimulation, mechanical traction, and bladder training, evaluation and treatment of functional loss due to related nerve, muscle, and skeletal dysfunctions and/or pain.

I understand that I may refuse any therapeutic procedure or treatment at any time.

Patient Name (or Responsible Party)

Signature

Date

PATIENT FINANCIAL RESPONSIBILITY

I hereby assign all physical therapy benefits to Southland Physical Therapy for services rendered to me or said minor patient. I authorize any holder of medical information about me or said minor to release to my insurance company any information needed to determine these benefits payable for related services. I understand that if my insurance benefits and/or eligibility DO NOT COVER OR APPROVE PAYMENT FOR SERVICES PROVIDED BY SOUTHLAND PHYSICAL THERAPY, I AM FINANCIALLY RESPONSIBLE AND AGREE TO PAY FOR ALL CHARGES RELATED TO SERVICES RENDERED. This includes, but is not limited to; services deemed 'non-covered' or 'not medically necessary' by my insurance.

I understand my signature requests that payment be made to Southland Physical Therapy and authorize release of medical information necessary to pay the claim.

Patient Name (or Responsible Party)

Signature

Date

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this policy carefully. For more detailed information, please request a printout.

Understand your health record and information:

When receiving physical therapy services from SOUTHLAND PHYSICAL THERAPY, INC. a record is made of your treatment. This record contains your symptoms, diagnoses, examinations, assessments, evaluation, and your treatment plan. It also contains daily treatment notes and progress notes.

Our pledge regarding medical information:

We understand that your medical information is personal and private. We are committed to protecting your information. Medical records are only disclosed in a limited amount of circumstances which may be regarding; **treatment, payment, review for quality of care, federal, state, or local law, and lawsuits/disputes**. If for any reason, you would like a copy of your entire record, please make your request in writing. For your protection, please have proper ID with you if picking up records in the office.

I have read and understand all information outlined above.

Patient Name (or Responsible Party)

Signature

Date

*If you would like more detailed information on any of our policies or procedures, please request a copy from the front office.