NEW PATIENT INFORMATION FORM

(First time patients)

Please complete entire form, print and circle where necessary.

Patient Name:_____DOB:___/____/_____

Do you have a prescription for physical therapy? **Y N** Referring Doctor:_____

Primary Care Physician (If different than referring Doctor): _____

Gender: **M F** Appointment reminders: **TEXT EMAIL**

Phone# (_____)_____-_____Email:_____

Preference on communication with Physical Therapist: **TEXT_____ EMAIL_____**

Employment Status: **Full Time Part Time Unemployed Retired**

Employer: _____Phone:_____

Social Security#_____

Emergency Contact/Phone :_____(___)___-____Relationship:_____

*If Under 18 or POA, Parent/Guardian:*_____Relationship:_____

Are there any customs, religious beliefs or wishes you would like your 360 PT to be aware of?

Yes / No If Yes, please explain:_____

Marital Status: **Married Single Divorced Widowed**

With whom do you live? **Alone Spouse Child(ren) Care attendant Parent(s) Other**

Does your home have**: Stairs Ramps Uneven Terrain Assistive Devices Elevator Other Obstacles**

Do you use: **Glasses Cane 2 Wheel walker 4 Wheel walker Motorized wheelchair**

Manual wheelchair Crutches Hearing aids Other:_____

Do you have Health Insurance: **Yes / No** Are you the policy holder: **Yes / No**
If no, who is the policy holder: Parent Guardian Spouse Other_____

Policy Holder Name:_____DOB:_____

MEDICAL HISTORY FORM

(Update every 6 months or when necessary)

Rate your overall health status: **Excellent Good Fair Poor** Height:___'___" Weight:_____lbs

Tobacco Use: **Y N** Year Quit:_____ Alcoholic Drinks:____Drinks per **Day Week**

Do you exercise beyond daily activities: **Y N** Days per week:_____ What type of exercise:_____

Any major life changes in the past year: **Y N** Explain:_____

Do you have any allergies: **Y N** Explain:_____

Please check if you have ever had:

□Arthritis
□Osteoporosis
□Heart problem
□Lung problem
□Diabetes
□Head injury
□Muscular dystrophy
□Seizures/epilepsy
□Thyroid problem
□Cancer
□Hepatitis
□Repeated infections
□Skin diseases
□Pacemaker
□Hernia
□Concussion
□AIDS/HIV
□Appendicitis
□Broken bones
□Blood disorders
□High blood pressure
□Stroke
□Hypoglycemia (low blood sugar)
□Multiple Sclerosis
□Parkinson's disease
□Allergies
□Developmental (growth) problem
□Tuberculosis
□Kidney problems
□Ulcers/stomach problems
□Depression
□Fibromyalgia
□Migraines
□Asthma
□Anemia
□Circulation/vascular problems

□Other_____

Within the past year have you had any of the following?

□Chest pain
□Heart palpitations
□Cough
□Hoarseness
□Shortness of breath
□Dizziness or blackouts
□Coordination problems
□Headaches
□Fever/chills/sweats
□Difficulty walking
□Joint pain or swelling
□Pain at night
□Difficulty sleeping
□Loss of appetite
□Nausea/vomiting
□Difficulty swallowing
□Bowel problems
□Weight loss/gain
□Urinary problems
□Weakness in arms or legs
□Loss of balance
□Hearing problems
□Vision problems
□ Other _____

Men: Prostate disease □Yes □No

Women: □Pelvic inflammatory disease □Endometriosis
□Trouble with your periods □Complicated pregnancy
□Currently pregnant

□Other _____

Current Medications:	Surgeries (include year)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

EVALUATION FORM

(For each new Case)

In order to evaluate your condition, please complete entire form as accurate as possible for ***THIS INJURY/EPISODE***.

Patient Name:_____Date:___/___/____

Has there been ANY changes to your medical history/medications since your last injury/episode here? Y N

Are you seeing anyone else for this problem:_____

Was this injury/episode cause by a motor vehicle accident? **Y N** Date of Accident: ___/___/____

Is this injury/episode related to a work injury: **Y N** Date of Injury:___/___/____

Current work status: **FT PT UNEMPLOYED DISABLED** Work Restrictions:_____

Have you fallen in the past 12 months: **Y N** How many times:_____ Which is your dominant hand: **R L**

Do you have difficulty walking/balance? **Y N** Any current restrictions:_____

What diagnostic tests have been performed for this problem? **X-ray CT scan MRI Other**

1	Where is your pain/problem?	
2	What caused your pain/problem?	
3	Have you had this same pain/problem before?	**N Y (Explain)**
4	What makes your pain/problem better?	
5	What makes your pain/problem worse?	
6	When did your pain/problem begin?	
8	On the scale, circle your average daily pain.	MILD MODERATE SEVERE 0….1….2….3….4….5….6….7….8….9….10

Please list **3 activities** in your life that are difficult to perform or you are having the most difficulty performing as a result of your injury or problem. Score each activity on a scale of 0 (unable to perform activity) to 10 (able to perform activity the same as before injury).

Activity Description		Score 0-10
1		
2		
3		

CONSENT TO TREATMENT

I understand that I have been referred for Physical Therapy treatment to 360 Physical Therapy, LLC. 360 Physical Therapy, LLC has described for me my individual treatment plan. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to this treatment plan that has been prescribed by my physician and/or recommended by my therapist. By signing this agreement, I consent to have 360 Physical Therapy, LLC provide treatment and care as prescribed by my physician and/or recommended by my therapist.

***Patient Signature*_____*Date*_____**

***Guardian Signature*_____*Date*_____**

HIPAA

Patient's Written Acknowledgement of Notice of Privacy Practices:

I_____ , acknowledge that I have been granted access to the notice of privacy practices and was given the ability to request a copy of 360 Physical Therapy's Notice of Privacy Practices and fully understand. I further acknowledge I have had all my questions answered to my satisfaction. I hereby authorize 360 Physical Therapy to disclose my protected health information to the following:

Name:_____Relationship to patient:_____

Name:_____Relationship to patient:_____

***Patient Signature*_____*Date*_____**

***Guardian Signature*_____*Date*_____**

CONSENT TO TREAT A MINOR

I hereby state that I am the legal guardian for the below referenced patient and I authorize the physical therapists and whomever they may designate as assistants at 360 Physical Therapy to administer physical therapy treatment care as deemed necessary to my minor child. I understand that at any time I am responsible for communicating any questions I may have in regard to treatment to the treating therapist or supervision therapist at the facility. I further understand it is my responsibility to understand upon conclusion of the evaluation appointment I should understand the indications and contraindications for treatment and should notify the evaluating therapist if I do not understand. This consent shall remain in effect through the course of treatment unless revoked in writing.

Printed Name of Parent or Legal Guardian:_____

Address:_____ Phone: _____

***Signature of Parent or Legal Guardian*: _____**

Witness:_____Date: _____