Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone (home) :_____ cell: _____

May we leave messages at the numbers above? Yes / No

Date of birth: _____/_____/_____

Email address:_____

Primary Care Physician or Practice name (Required): _____

Referring physician phone number:_____

Referring physician email or Fax : _____

Emergency Contact:_____

Phone number: _____

Relationship to you: _____

How did you find Inner Strength Physical Therapy and Wellness?

_____

INNER STRENGTH
Physical Therapy & Wellness

Past Medical History and Current Concerns

Name: _____ Male___ Female__ Height: _____ Weight: _____lbs

Occupation: _____ General Health: Excellent___Good___Fair___Poor___

Dietary Habits: _____

Exercise Habits: _____

Smoking: Yes / No Alcohol: Yes / No If yes, how many drinks per day___ per week___ occasional___

Allergies/Medical conditions:_____

Medications: _____

Assistive Devices: None___ Cane___ Walker___ Hearing aids___ Glasses___

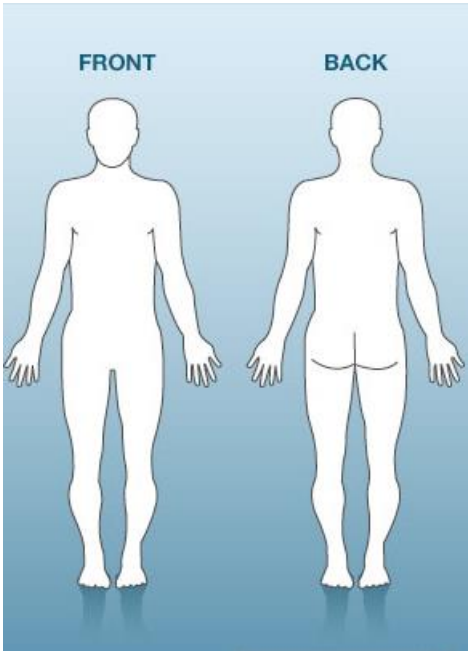
Past Injuries/Surgeries with dates:_____

_____

Medical Tests: X-ray___ MRI___CT scan___ Bone density___ EMG___ Blood test ___Urinalysis___ Other

Tests/Results: _____

Where do you feel it? Describe your symptoms



Indicate on the drawing the location of the pain you are experiencing

Pain level in the last week (circle): No pain Mild Moderate Severe
0 1 2 3 4 5 6 7 8 9 10

How would you describe the pain? Dull Achy Sharp Numb Tingling Other:

When did your symptoms start? _____/_____/_____

How did your symptoms develop? Injury (explain): _____date: ____/____/____

Surgery (type):_____date: ___/_____/_____ Unknown cause____

Have you received other treatment for your current condition? Yes / No

If yes, what type of treatment? _____ Was it helpful? Yes / No

Have you ever had this condition before? Yes / No If yes, when? _____

Did you receive treatment for prior episodes? Yes/ No
If yes, what type of treatment? _____ Was it helpful? Yes / No

What makes your symptoms worse? _____

What makes your symptoms better? _____

What are your goals/expectations for physical therapy? _____

What daily activities are affected most by your current symptoms?

1.

2.

3.

4.

5.

INNER STRENGTH
Physical Therapy & Wellness

Practice Policies

NEW PATIENTS
Inner Strength Physical Therapy and Wellness is a Direct Access Physical Therapy provider. This means you do not need a prescription to be evaluated and for us to initiate treatment. If you have a valid prescription, please bring it with you in addition to your completed past medical history forms. If you do not have the forms filled out prior to your evaluation, please come 15 minutes early to complete them, so we may begin at the scheduled appointment time.

RETURNING PATIENTS
Please bring a new prescription if you were referred, and update appropriate areas of your intake forms to describe your current concerns/symptoms.

FEES/PAYMENTS
Payment is required at the time services are rendered. For your convenience, we accept cash, credit cards and checks. Inner Strength Physical Therapy and Wellness reserves the right to charge an additional $50.00 for each returned check.

PRESCRIPTION/PHYSICIAN REFERRAL
If you wish to seek out insurance reimbursement, please bring a valid prescription (within 30 days), from a licensed physician (M.D or D.O), nurse practitioner, chiropractor, or dentist. We will send your plan of care to your specified primary care provider, and their signature on that document is equal to a prescription. Your insurance company may require a prescription or a copy of the signed plan of care before they provide coverage. You also have the option not to submit for reimbursement.

TREATMENT SESSIONS
A session typically lasts for one hour. This includes 45-50 minutes of evaluation and/or treatment, and 10-15 minutes for printing out home exercises, payment, and scheduling. Wear or bring clothes that are appropriate for moderate exercise and that allow for the torso, arms and legs to be exposed for assessment (shorts, yoga pants or sweatpants and tee-shirt, sports bra or tank top).

CONSENT TO TREAT
The patient hereby consents to the administration of appropriate evaluation and therapeutic procedures as requested by the physician prescribing care and/or via direct access and subsequent approval of the patient's primary care provider if required. The therapist will monitor progress and adjust treatment frequency and duration according to medical necessity as needed.

MEDICAL RECORDS

We understand that your present and past medical information is personal. We are committed to protecting information about you. We create a record of care and services you receive at Inner Strength Physical Therapy and Wellness that is maintained electronically via WebPT. This allows for us to remain free of paper charts that are prone to damage, loss, or security concerns. We need these records to provide you with quality care, to comply with legal requirements and to meet your needs for reimbursement. This notice applies to all of the records generated. The law requires us to:
a. Make sure that medical information that identifies you is kept safe and secure in a HIPPA compliant manner.
b. Give you this notice of our legal duties and privacy practices with respect to medical information about you.

NEWSLETTER & CONTACT
If you supplied an email address, you will be signed up for our email newsletter. This will include updates, news, classes, deals, presentations and the like. If you do not wish to receive these, please initial here:

TARDINESS
We ask that you arrive on time for your appointments and that you are considerate of the next patient's time when your session ends. If you arrive late, your treatment time will be shortened, and you will be responsible for payment of the full visit.

CANCELLATION/NO SHOW
Please kindly give 24 hours' notice if you are unable to keep your appointment.

PELVIC HEALTH PATIENTS:
If you would like to provide a chaperone for your comfort during your Initial Evaluation or Treatment Sessions you are welcome to do so. Inner Strength Physical Therapy and Wellness is unable to provide a patient chaperone.

By signing below, I certify that I have read the above policies, understand and will comply with them. I agree that Inner Strength Physical Therapy and wellness retains the right to charge my credit card for scheduled appointments missed by lateness, late cancellation or no-show activity, as described above.

SIGNATURE_____

DATE_____

PRINTED NAME_____

Would you like to be reminded of future appointments (Circle One)? TEXT PHONE CALL EMAIL