TAYLOR PHYSICAL & OCCUPATIONAL THERAPY

PATIENT MEDICAL HISTORY

_____New Patient _____Established Patient

Name_____ Birth Date_____ Age_____
Home Address_____ City_____ State_____ Zip_____
Where Employed _____
Home Phone _____ Work Phone _____ Cell Phone _____
Email address_____ May we contact you by email? _____Yes _____ No
Spouse's Name _____ Employer _____
Emergency Contact _____Relation_____ 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? _____
_____

Have you fallen 2 or more times in the last year or 1 fall with significant injury? Yes No

Do you have or have you had any of the following?

___Heart Problems
___Pacemaker
___High/Low Blood Pressure
___Circulatory Problems
___COPD/Emphysema
___Asthma
___Shortness of Breath
___Chronic Ulcer
___Anemia
___History of Smoking
___Diabetes
___Kidney Disease
___Cancer
___Hepatitis
___Tuberculosis
___Rheumatic Fever
___Multiple Sclerosis
___Blood Clots
___Back pain/sciatica
___Osteoporosis
___Artificial Joints/Implants
___Seizures
___Dizziness/Vertigo
___Depression/Mental Illness
___Stroke
___Hearing/Visual Difficulties
___Rheumatoid Arthritis
___Other Arthritic Conditions
___Dementia
___Currently or possibly pregnant

List any other medical information or special tests you've completed that you believe would be beneficial for us to be aware of:
_____
_____

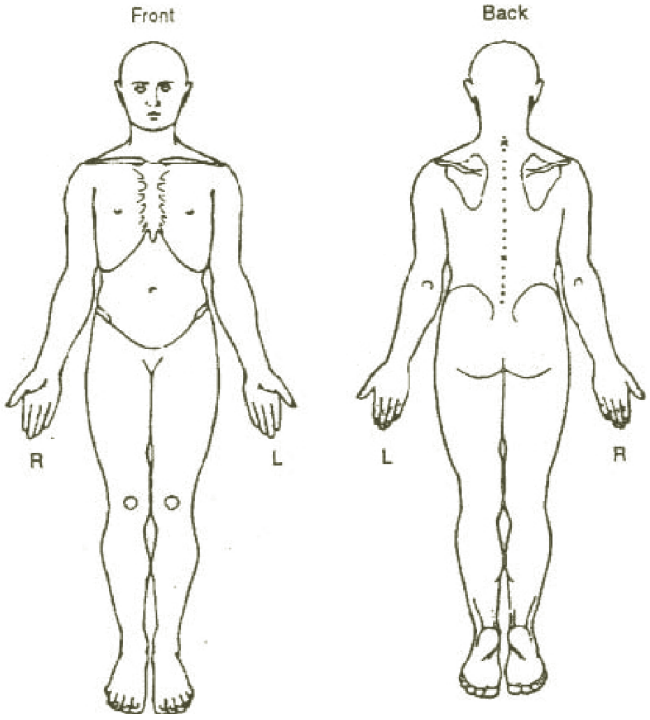
Current Medications _____
_____

Height_____ Weight_____

(**Please fill out back page**)

PATIENT MEDICAL HISTORY

Mark on the diagram below where you currently are 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) _____Frequently (12-23 hours/day)
_____Occasionally (6-12 hours/day) _____Not frequently (0-6 hours/day)

Please list other treatment you have received for this condition _____

_____

Who was your referral source for therapy? ☐ Physician ☐ Self-Referral

How did you hear about Taylor Physical Therapy? (Please check both category and subcategory)

☐ Returning Patient
- ☐ Newsletter
- ☐ Postcard

☐ Advertising
- ☐ Social Media
- ☐ Commercial
- ☐ Newspaper
- ☐ Flyer
- ☐ Radio

☐ Word of Mouth
- ☐ Friend or Family
- ☐ Community Event
- ☐ Taylor Employee

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

Patient's Signature _____Date_____
Signature of
Personal Representative _____Date_____

Patient did not sign for the following reason: ☐ Minor ☐ Physically Unable ☐ Has Legal Guardian

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