New Patient Information

Contact Information

Patient Name:			Phone:
Date of Birth:	Age		Cell:
(If minor) Parent or Legal Guardian:			Relationship:
Address:	Street:		
	City:	State:	Zip:
Emergency Contact:	Phone:		Relationship:

Appointment Reminder Consent

Please select ONE method below to contact you with appointment reminders. Choose either email or text:

☐ **Email** **Body Logic Physical Therapy may send email messages to confirm my upcoming appointments.**

Email address: _____

—or—

☐ **Text** **Body Logic Physical Therapy may send cell phone text messages to confirm my upcoming appointments.** *I recognize that normal text messaging rates may apply.*

Cell phone number: _____

In order to set up your text message reminders, we need to know your cell phone carrier. Please indicate your carrier below:

☐ ALLTel	☐ Cricket Wireless	☐ Qwest	☐ Verizon
☐ AT&T	☐ Metrocall	☐ Sprint PCS	☐ Virgin Mobile
☐ Boost Mobile	☐ MetroPCS	☐ T Mobile	☐ Xfinity
☐ Cingular	☐ Nextel	☐ US Cellular	

New Patient Consent

I _____ , understand that as part of my health care, Body Logic Physical Therapy originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify, that services billed were actually provided and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes, and the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care options.

I understand that Body Logic Physical Therapy is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by section 164.506 of the code of Federal Regulations.

I further understand that Body Logic Physical Therapy reserves the right to change their notice and practices and prior to implementation, in accordance with section 164.520 of the code of Federal Regulations. Should Body Logic Physical Therapy change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail, or if I agree; email). I understand that as part of this organizations treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses including disclosures via fax.

I authorize assignment of benefits to Body Logic Physical Therapy.

I understand that my diagnosis and treatment plan will be discussed during my appointment and I have the right to question and/or refuse any treatment offered.

We reserve the right to charge an appointment fee of $50.00 for any scheduled appointment canceled without 24-hour notice or a no show. In the event of 2 (two) consecutive "no show" all future appointments will be canceled and discharge note will be sent to your referring physician.

Patients are responsible for any portion of their balance that insurance will not cover. There will be a $25.00 charge for all returned checks.

I fully understand and accept the terms of this consent.

X_____ X _____
Print Name Date

X _____ X _____
Signature of Patient OR Signature of Parent or Guardian

Physical Therapy Medical Screening Questionnaire

Patient Information

Name: | Age: | Date:

Gender: ☐ Male ☐ Female ☐ Trans ☐ Other_____ | Smoker: ☐ Yes ☐ No | Pregnant: ☐ Yes ☐ No

Occupation:

Describe your exercise routine:

Past Medical History Please select each condition that you have been told you have (or had):

☐ Cancer	☐ Diabetes	☐ Kidney Disease	☐ Liver Disease
☐ Stroke	☐ High Blood Pressure	☐ Heart Disease	☐ Angina/Chest Pain
☐ Ulcers	☐ Fibromyalgia	☐ Osteoporosis	☐ Osteoarthritis
☐ Rheumatoid Arthritis	☐ Sexually Transmitted Disease	☐ Allergies/Asthma	☐ Lung Disease

Other illness or injury, If yes, explain:

Do you take blood thinners? ☐ Yes ☐ No | Are you allergic to latex ☐ Yes ☐ No

During the past month, have you been feeling down, depressed, or hopeless? ☐ Yes ☐ No

During the past month, have you been bothered by little or no interest or pleasure in doing things? ☐ Yes ☐ No

Past surgical history (list all & date):

Current medications (or provide list separately):

Have you had an x-ray, MRI, or other imaging study?

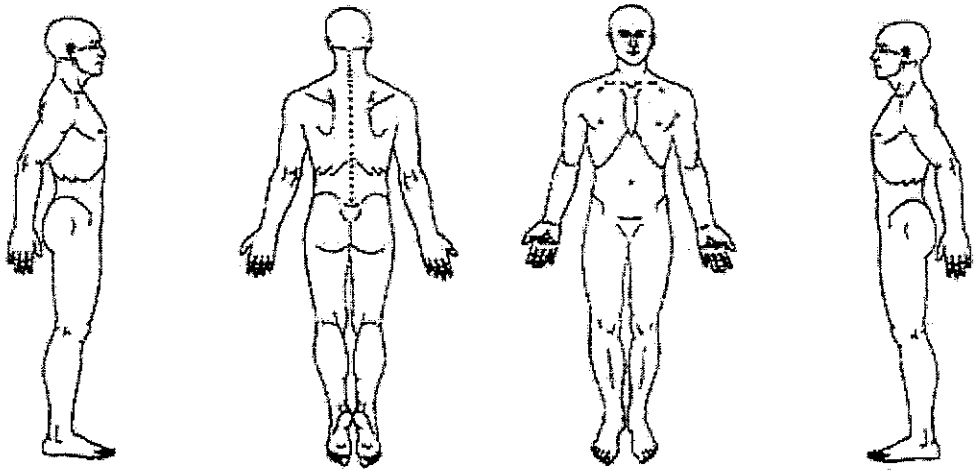
Current Symptoms Please select all that apply:

☐ Fever/chills/sweats	☐ Poor balance (falls)	☐ Unexplained weight loss	☐ Numbness or Tingling
☐ Changes in appetite	☐ Difficulty swallowing	☐ Depression	☐ Shortness of breath
☐ Dizziness	☐ Headaches	☐ Nausea/Vomiting	☐ Increased pain at night
☐ Changes in bowel or bladder function			

Where are you currently having symptoms?

Body Chart:

Please mark the areas where you feel pain on the chart to the right.



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Physical Therapy Medical Screening Questionnaire (continued)

Current Symptoms (continued)

What date (approx.) did your present pain start? | How (gradually, suddenly, injury)?

Your symptoms are currently: ☐ Getting better ☐ About the same ☐ Getting worse

Have you ever had this problem before? ☐ Yes ☐ No

If so, how was the problem treated?

How long did it take for you to feel better?

How are you able to sleep at night? ☐ Well ☐ Moderate difficulty ☐ Only with medication

What is your personal goal for therapy?

Number of falls in past year: | Do you feel unsteady walking/standing? ☐ Yes ☐ No

Are you worried about falling? ☐ Yes ☐ No

At the present time, would you say that your health is? ☐ Excellent ☐ Very good ☐ Fair ☐ Poor

On the scales below, please check the number which best represents the severity of your pain:

Pain at present

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain Imaginable

Best for the last 48 hours

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain Imaginable

Worst for the last 48 hours

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain Imaginable

Please check the number below which best represents your overall average level of function:

Cannot do anything	0	1	2	3	4	5	6	7	8	9	10	Able to do everything

What makes your symptoms better?

What makes your symptoms worse?

Please list the best and worst time of day for your symptoms: Best: Worst:

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with. List them below:

1)

2)

3)

Do you have any barriers to learning? If so list: