**WELCOME**

Welcome to My Restorative Physical Therapy (Jennifer Prewitt Wellness LLC). It is an honor that you have chosen me to provide your physical therapy care! Please complete the following information that will allow us to provide you with the best possible care.

**PATIENT INFORMATION**

**Patient Name:** Click or tap here to enter text. **Sex:** Choose an Item

**Date of Birth:** Click or tap here to enter text. **Age:** Click or tap here to enter text.

**Address:** Click or tap here to enter text.

**Preferred Contact (Please Check Below):**

**Phone (Home):** Click or tap here to enter text.

**Phone (Cell):** Click or tap here to enter text.

**Phone (Work):** Click or tap here to enter text.

**Permission to Leave a Detailed Voicemail?  Yes No**

**Email Address:** Click or tap here to enter text.

**\*For Care/ Communication Purposes Only. My Restorative Physical Therapy Will Never Share or Sell Your Information.**

**Automated Appointment Reminder Preference:  Email  Voice Call  Text Message**

**In Case of Emergency, Please Contact Name:** Click or tap here to enter text.

**Contact’s Phone Number:** Click or tap here to enter text.

**Relationship to You:** Choose an item.

**If Under the Age of 18, Guardian Name:** Click or tap here to enter text.

**Guardian’s Phone Number:** Click or tap here to enter text.

**Relationship to Patient:** Choose an item.

**How Did You Hear About Us?** Choose an item.

**If Other (Please Describe):** Click or tap here to enter text.

**SUMMARY OF PRESENT CONDITION**

**Diagnosis or Chief Complaint (s):** Click or tap here to enter text.

**Date of Injury/ Onset:** Click or tap here to enter text.

**Referring Physician or Primary Care Physician:** Click or tap here to enter text.

**If You Had Surgery, Surgical Procedure Name:** Click or tap here to enter text.

**Surgery Date:** Click or tap to enter a date. **Surgeon Name:** Click or tap here to enter text.

**OPT IN FOR ELECTRONIC SIGNATURE**

I opt to type my name in the entry fields below as my legally binding electronic signature.

I opt to sign manually and am responsible for submitting my signatures to My Restorative Physical Therapy and Physical Therapy Dynamix.

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient or Parent/ Guardian if Under Age 18

**CONSENT TO RECEIVE TREATMENT**

By signing below, I agree to the following:

* I voluntarily give My Restorative Physical Therapy and Physical Therapy Dynamix my consent to receive services which may include diagnostic procedures, examinations, and treatment according to the recommended plan of treatment as discussed with my therapist. I understand that physical therapy involves manual techniques that require appropriate physical contact by the healthcare provide and staff.

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient or Parent/ Guardian if Under Age 18

**CONSENT TO RECEIVE TELEHEALTH TREATMENT**

By signing below, I agree to the following:

* I voluntarily give My Restorative Physical Therapy and Physical Therapy Dynamix my consent to receive physical therapy services via Telehealth which may include diagnostic procedures, examinations, and treatment according to the recommended plan of treatment as discussed with my therapist.
* I understand that telehealth physical therapy cannot include all possible physical therapy assessment and treatment options that would be available in a standard in-person treatment session. Such assessments and treatments may include, but is not limited to, MMT (manual muscle testing), Special Tests, joint mobility assessment, PROM (passive range of motion) assessment, manual intervention, soft tissue mobilization, joint mobilization, PROM (passive range of motion), manual/ facilitation cues, and manually-resisted exercise.
* The physical therapist reserves the right to discontinue a Telehealth physical therapy session at any time if delivery of this treatment is deemed unsafe or the determination is made that physical therapy must be conducted in-person for the patient to benefit.
* I understand most health insurance carriers do not cover Telehealth physical therapy services. My Restorative Physical Therapy and Physical Therapy Dynamix will call to verify if your insurance plan covers physical therapy via Telehealth, but if it does not, a cash rate will be established and payment is due on date of service.

I am voluntarily making the choice to participate in Telehealth Physical Therapy Services with My Restorative Physical Therapy and Physical Therapy Dynamix.

I decline participation in Telehealth Physical Therapy Services.

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient or Parent/ Guardian if Under Age 18

**CANCELLATION AND BROKEN APPOINTMENT POLICY**

By signing below, I understand the following:

* We would like you to be aware of our Cancellation/ Broken Appointment Policy. **Any appointment cancelled or broken within 24 hours of their scheduled time will be assessed a $50 fee.** The cancellation fee is not covered by insurance and will be collected at the time of your next visit or billed directly to you as an out of pocket expense.

If a cancellation is unavoidable we do ask that you give us as much notice as possible so we may offer that appointment to another patient.

Successful physical therapy depends on a strong working partnership between the patient and the physical therapist. Maximum progress and outcomes are achieved when the patient is an active participant in their home exercise program and attends treatment as recommended by their physical therapist. **It is very important to attend each appointment when it is scheduled.**

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient or Parent/ Guardian if Under Age 18

**RECEIPT OF PRIVACY PRACTICES**

By signing below, you acknowledge receipt of the Noticy of Privacy Practices of My Restorative Physical Therapy (Jennifer Prewitt Wellness LLC) and Physical Therapy Dynamix. You are also authorizing My Restorative Physical Therapy (Jennifer Prewitt Wellness LLC) and Physical Therapy Dynamix to release your records to your insurance company and physician. Please understand your records are held in strict confidence and we will not release them to any unauthorized person. Our Notice of Privacy Practices provides further information about how we may use and disclose your Protected Health Information (PHI). We encourage you to read it in full.

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient or Parent/ Guardian if Under Age 18

**Please Include the Names of Any Person(s) With Whom We Are Allowed to Discuss Your Condition, Care, and/ or Billing Information. Examples May Include Family Member, Caregiver, Healthcare Provider, Lawyer, or Case Manager.**

**Name:** Click or tap here to enter text. **Relationship to You:** Choose an item.

**Name:** Click or tap here to enter text. **Relationship to You:** Choose an item.

**Name:** Click or tap here to enter text. **Relationship to You:** Choose an item.

I Authorize My Restorative Physical Therapy (Jennifer Prewitt Wellness LLC) and Physical Therapy Dynamix to discuss my medical condition, care, and/ or billing information with the above-named person(s).

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient or Parent/ Guardian if Under Age 18

**HISTORY OF PRESENT CONDITION**

**What are You Seeing Us For?** Click or tap here to enter text.

|  |  |
| --- | --- |
| **Please Indicate Where You Have Pain/ Symptoms:** Click or tap here to enter text.  Image result for body sheet | **How Would You Describe Your Symptoms?**  Sharp  Throbbing  Dull Shooting  Numbness Aching  Tingling Burning  Other: Click or tap here to enter text.  **Please Indicate Your Symptom Intensity:**  **(0= Lowest, 10= Highest)**  **Current:** Click or tap here to enter text.  **At Best:** Click or tap here to enter text.  **At Worst:** Click or tap here to enter text. |
| **When Did this Issue Begin?**  Click or tap here to enter text.  **Describe the History of this Problem:**  Click or tap here to enter text.  **Onset of Symptoms Was:** Choose an item.  **Overall, My Symptoms are:**  Choose an item.  **Similar Symptoms in the Past?**  Choose an item.  **If Yes, When? \_\_\_\_\_\_\_\_\_\_\_** | **What Aggravates Your Symptoms?**  Sitting  Standing  Lying down  Bending  Walking  Sleeping  Stairs  Cough/ Sneeze  Reaching  Turn/ Twist  Lifting  Stress  Other: Click or tap here to enter text.  **What Relieves Your Symptoms?**  Click or tap here to enter text. |

**HISTORY OF PRESENT CONDITION (CONTINUED)**

**Have you had any treatment or tests for this condition?**

|  |  |  |
| --- | --- | --- |
| Physical Therapy Massage Therapy  Chiropractic Care  Home Health  Exercise | Medication  Injection  Hospitalization  Bed Rest  Casting/ Bracing | X-ray  CT Scan  MRI  EMG  Bone Scan  Other Click or tap here to enter text. |

**Since your symptoms began, have you had any of the following**

|  |  |
| --- | --- |
| Bowel or Bladder Issues  Weakness  Dizziness or Fainting  Fever/ Chills/ Sweats  Significant Weight Change  Hearing or Vision Problems | Numbness or Tingling  Difficulty Swallowing  Night Pain  Numbness in the anal or genital area  Vague Feeling of Bodily Discomfort  NONE |

**SOCIAL LIFE**

|  |  |
| --- | --- |
| **In General, My Overall Health is:**  Choose an item.  **My Exercise/ Activity Level is:**  Choose an item.  **If Active, Please Describe:**  Click or tap here to enter text. | **Occupation:**  Click or tap here to enter text.  **My Job Involves:**  Choose an item.  **Other:** Click or tap here to enter text.  **My Current Living Situation:**  **I Live:** Choose an item.  **Stairs:  Yes  No** |

**MEDICAL HISTORY**

**Do you currently have or have you had any history of any of the following?**

|  |  |  |
| --- | --- | --- |
| Diabetes  High Blood Pressure  Cancer/ Tumor  IBD (Chrohn’s, UC)  Anemia  Stroke  Osteoporosis  Nausea/ Vomiting  Cardiac Arrhythmias  Pacemaker  Blood Clots Peripheral Vascular Dis.  Bruising Easily  Neurological Condition  Sleep Disorder | Seizures/ Epilepsy  Thyroid Problem  Pulmonary Condition  Multiple Sclerosis  Kidney Problem  Parkinson’s Disease  Fractures  Joint Replacement  Arthritis/ Swollen Joints  Rheumatoid Arthritis  Fibromyalgia  Gout  Headache/ Migraine  Dizziness/ Vertigo  Smoking | Loss of Balance/ Falls  Shortness of Breath  Infectious Disease  Use of Steroids/ Inhalants  Currently Pregnant  Depression  Chemical Dependency  Sensitivity to Heat/ Ice  Allergy to Adhesive/ Tape/ Lotions  Angina  Coronary Artery Disease  Other:  Click or tap here to enter text. |

**Please List Any PREVIOUS Surgeries (Procedure AND Approximate Date):**

1. Click or tap here to enter text. **Date:** Click or tap to enter a date.
2. Click or tap here to enter text. **Date:** Click or tap to enter a date.
3. Click or tap here to enter text. **Date:** Click or tap to enter a date.
4. Click or tap here to enter text. **Date:** Click or tap to enter a date.
5. Click or tap here to enter text. **Date:** Click or tap to enter a date.

**Medication List (Attach Page if Preferred)**

|  |  |
| --- | --- |
| **Medication Name** | **Dosage/ Frequency** |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
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