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: _____ Sex: _____

Date of Birth: _____ Age: _____

Address: _____

_____

Preferred Contact (Please Check Below):

☐ **Phone (Home): _____**

☐ **Phone (Cell): _____**

☐ **Phone (Work): _____**

Permission to Leave a Detailed Voicemail? ☐ Yes ☐ No

Email Address: _____

***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: _____

Contact's Phone Number: _____

Relationship to You: _____

If Under the Age of 18, Guardian Name: _____

Guardian's Phone Number: _____

Relationship to Patient: _____

How Did You Hear About Us? ☐ Internet ☐ Friend/ Family ☐ Doctor

☐ Other (Please Describe): _____

Completed Paperwork Can Be Submitted:
At Initial Evaluation
Via Email: jenny@myrestorativept.com
Via Fax: (425) 207-4980

SUMMARY OF PRESENT CONDITION

Diagnosis or Chief Complaint (s): _____

Date of Injury/ Onset: _____

Referring Physician or Primary Care Physician: _____

If You Had Surgery, Surgical Procedure Name: _____

Surgery Date: _____ Surgeon Name: _____

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.

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- 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

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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: _____ Relationship to You: _____

Name: _____ Relationship to You: _____

Name: _____ Relationship to You: _____

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

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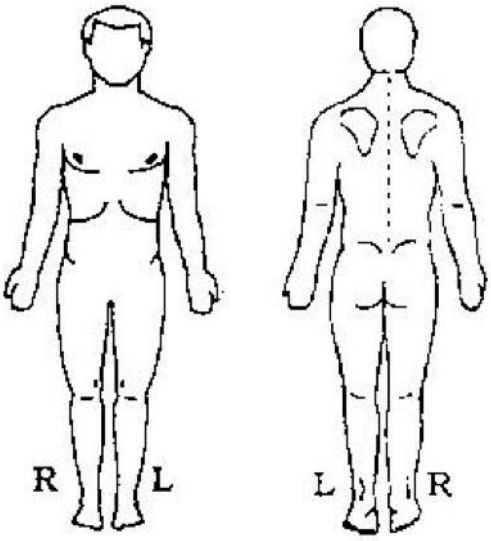
HISTORY OF PRESENT CONDITION

What are You Seeing Us For? _____

_____

Please Indicate Where You Have Pain/ Symptoms:



When Did this Issue Begin?

_____

Describe the History of this Problem:

_____

_____

Onset of Symptoms Was:

☐ **Gradual** ☐ **Sudden**

Overall, My Symptoms are:

☐ **Improving** ☐ **Worsening**

☐ **Staying the Same**

Similar Symptoms in the Past?

☐ **Yes, When?** _____ ☐ **No**

How Would You Describe Your Symptoms?

☐ Sharp ☐ Throbbing

☐ Dull ☐ Shooting

☐ Numbness ☐ Aching

☐ Tingling ☐ Burning

☐ Other: _____

Please Indicate Your Symptom Intensity: (0= Lowest, 10= Highest)

Current: _____

At Best: _____

At Worst: _____

What Aggravates Your Symptoms?

☐ Sitting ☐ Standing

☐ Lying down ☐ Bending

☐ Walking ☐ Sleeping

☐ Stairs ☐ Cough/ Sneeze

☐ Reaching ☐ Turn/ Twist

☐ Lifting ☐ Stress

☐ Other: _____

What Relieves Your Symptoms?

_____

_____

_____

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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

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:

- ☐ Poor
- ☐ Okay
- ☐ Good
- ☐ Very Good
- ☐ Excellent

My Exercise/ Activity Level is:

- ☐ Inactive
- ☐ Active
- ☐ Very Active

If Active, Please Describe:

_____

_____

_____

Occupation:

_____

My Job Involves:

- ☐ Sitting
- ☐ Standing
- ☐ Lifting/ Labor

My Current Living Situation:

I Live:

- ☐ Alone
- ☐ With Family
- ☐ With Friends

Stairs: ☐ Yes ☐ No

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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: _____
  _____
  _____

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

1. _____ **Date:** _____
2. _____ **Date:** _____
3. _____ **Date:** _____
4. _____ **Date:** _____
5. _____ **Date:** _____

Medication List (Attach Page if Preferred)

Medication Name	Dosage/ Frequency

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