Schultz
PHYSICAL THERAPY

Patient Registration

Patient Name: _____

Date of Birth: _____ Male / Female Married / Single / Other

Address: _____ City: _____

State: _____Zip: _____

Email Address: _____

Home Phone:_____ Work: _____ Cell: _____

Social Security #: _____

Emergency Contact Name: _____ Relationship:_____

Phone: _____

Referred to Clinic by (circle one):

Dr. referral / Family / Friend / Former Patient / Newspaper / Phone Book / Internet / Other

Name of Referral Source (if applicable): _____

By signing this form, I attest that the above information is true, correct, and complete to the best of my knowledge.

_____ _____

Patient / Parent / Guardian Signature Date

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Consent to Treatment

1. I have presented myself to this facility for therapy treatments and consent to the care (history, physical examination, treatment, etc.) that will be provided by my therapist.
2. I realize I have the right to refuse any treatments or procedures to the extent permitted by law. I acknowledge that the delivery of health care does not guarantee results of any treatments at this facility. I understand that information from any medical record(s) kept by this facility may be used for educational, administrative, and/or facility approved purposes when my personal identity will not be revealed.
3. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service. I am responsible for any services not covered by this authorization. I have read and fully understand the Patient Financial Responsibilities Form.
4. Worker's Compensation - I hereby authorize Schultz Physical Therapy to receive my records related to my work injury.
5. I hereby authorize the use of telehealth, interactive video, audio and telecommunication technology when necessary to complement and enhance my treatment.

_____(initial)

Photo/Video Authorization

I grant to Schultz Physical Therapy and its affiliated entities, and its representatives and employees (collectively the "Company") the right to take photographs and/or videos of me in connection with my participation in physical therapy services. I authorize the Company, to copyright, use and publish the same in print and/or electronically. I agree that the Company may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content and waive any right to compensation therefore. I understand that I may revoke this authorization but only in writing delivered to the clinic office manager. I understand that if I choose to revoke this Authorization, the revocation will not be effective for any uses and/or disclosures of my protected health information that have already been made in reliance on this Authorization._____(initial)

Notice of Privacy Practices

By signing this form, I acknowledge that Schultz Physical Therapy has made its' Privacy Notice available to me, which explains how my health information will be handled in various situations. I understand that I may discuss my concerns and/or any questions I have concerning this Privacy Notice with Schultz Physical Therapy representatives.

PT Benefits Provided by Your Insurance Company

I hereby authorize my insurance benefits be paid directly to Schultz Physical Therapy. I acknowledge that my physical therapy benefits have been explained to me to my satisfaction. I understand that I am ultimately responsible for any copays, deductible(s), and/or co-insurance. I acknowledge that I should contact a representative of Schultz Physical Therapy if I do not understand my benefits, have questions regarding payment due, or if I am unable to provide payment for my services prior to receiving treatment. **I understand that the information provided regarding my insurance is an estimate and a quote of benefits and may not reflect the exact balance owed. I acknowledge that I am responsible for any balance not covered by my insurance and that I have the right and responsibility to follow-up with my insurance for specific questions regarding my individual policy.**_____(initial)

Communication: I consent to receive information (such as appointment reminders, patient surveys, and other information relating to the physical therapy services provided to you) via the communication channels for which you provided the contact information including via phone, text, and email. _____(initial)

No Show & Cancellation Policy

By signing this form, I acknowledge that I have read the No Show & Cancellation Policy and it has been explained to me. I understand that I am responsible for any fees incurred due to the violation of the No Show & Cancellation Policy. I acknowledge that I should contact a representative of Schultz Physical Therapy if I do not understand this policy or have questions regarding this policy. _____(initial)

Release of Information

I authorize the following individuals to receive information regarding my diagnosis, treatment, and billing:

Name:	Relationship:

Authorization

I acknowledge, as indicated by my signature below, that I have read and fully understand this form in entirety. By initialing in the respective places on this form and signing below, I am acknowledging that I have read, understand, consent to, authorize, and agree to all policies and procedures on this entire form.

_____
Patient Name (please print)

_____
Patient or Guardian Signature Date

_____
Schultz Physical Therapy Employee Signature Date

MEDICAL HISTORY FORM

Patient Name: _____ **Date:** _____

Gender: ☐ Male ☐ Female **Date of next Physician's visit:** ____/____/____

Smoker: ☐ Yes ☐ No **Are you presently working?** ☐ Yes ☐ No **Occupation:** _____

Pregnant: ☐ Yes ☐ No **Describe your regular exercise routine:** _____

Date of injury / onset: ____/____/____ **Have you ever had these symptoms before?** ☐ Yes ☐ No

Where are you currently having symptoms? _____ **How did they start?** _____

My symptoms are currently: ☐ Getting Better ☐ About the Same ☐ Getting Worse

Have you received any treatment for this problem? ☐ Yes ☐ No **If so, how was the problem treated?** _____

Have you had an x-ray, MRI, or other image study? ☐ Yes ☐ No **If yes, please specify** _____

Check which apply to your symptoms:

☐ Work related injury ☐ Recurrence of previous injury
☐ Motor vehicle accident ☐ Injury related to lifting ☐ Injury related to falling
☐ Cause unknown ☐ Athletic / recreational injury ☐ Other: _____

Have you had a related surgery? ☐ Yes ☐ No

Have you ever been told you have (or had)?

	Yes	No		Yes	No
Diabetes (type 1 / type 2)	☐	☐	Osteoarthritis	☐	☐
Chest Pain / Angina	☐	☐	Osteoporosis	☐	☐
High Blood Pressure	☐	☐	Cancer	☐	☐
Heart Disease	☐	☐	Rheumatoid Arthritis	☐	☐
Seizures	☐	☐	Asthma	☐	☐
Lung Disease	☐	☐	Liver/Gallbladder Disease	☐	☐
Kidney Disease	☐	☐	Sexually Transmitted Disease/HIV	☐	☐
Skin Abnormalities	☐	☐	Fibromyalgia	☐	☐
Stroke/CVA	☐	☐	Allergies to tape	☐	☐

Currently I am experiencing:

	Yes	No		Yes	No
Unexplained weight loss	☐	☐	Changes in appetite	☐	☐
Fatigue	☐	☐	Dizziness	☐	☐
Changes in bowel or bladder function	☐	☐	Nausea/vomiting	☐	☐
Numbness or tingling	☐	☐	Poor balance (falls)	☐	☐
Shortness of breath	☐	☐	Difficulty swallowing	☐	☐
Fever/chills/sweats	☐	☐	Headaches	☐	☐
Increased pain at night	☐	☐	Depression	☐	☐

Approximate ounces of water consumed each day: _____

During the past month, have you often been bothered by feeling down, depressed, or hopeless? YES NO

During the past month, have you often been bothered by little interest or pleasure in doing things? YES NO

On the scales below, please circle the number which best represents the severity of your pain.

Average for the last 48 hours:

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

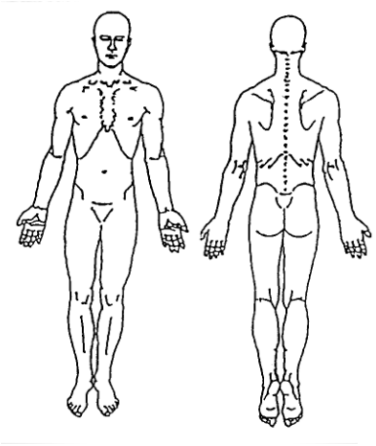
Best for the last 48 hours:

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 mark area below where you are experiencing symptoms and briefly describe.



Pain description: _____

_____

(numbness, burning, stabbing, aching, pins & needles, sore, tight, tingling, dull)

Please circle 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? _____

Please circle the activities which make your pain worse?

Lying Down Standing Walking Stress Sitting

Any other activities that make your pain worse? _____

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

<u>Aggravating Factors:</u> Identify up to 3 important activities that you are unable to do or are having difficulty with because of your problem. List them below:

1.) _____

2.) _____

3.) _____

By signing this form, I attest that the above information is true, correct, and complete to the best of my knowledge.

_____

(Patient Signature) (Date)