PHYSICAL THERAPY
UNLIMITED, P.A.

James Macbeth, B.A., P.T.
QA05729

AUTHORIZATION
FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Patient DOB: _____

Address: _____

Phone: _____

I, _____ hereby authorize _____

_____

to release my medical evaluations, progress notes, chart notes, and /or other medical information or records, as requested by Physical Therapy Unlimited.

_____ _____

Patient's Signature Date

Physical Therapy Unlimited ~ New/Returning Patient Information

Please Print Legibly, and Complete All Information.

Patient Information

Patient's Name: _____

Date of Birth: _____ Gender: ❑Male ❑Female

Parent/Guardian: _____

Address: _____

City, State, Zip: _____

Social Security Number: _____

Home Phone: _____

Cell Phone: _____

Employer: _____

Work Phone: _____

Email Address: _____

Referral Information

How did you hear about us?_____

Referring Physician: _____

Primary Physician: _____

IS THIS INJURY A RESULT OF (please check one):

❑Worker's Comp ❑ Motor Vehicle ❑Neither/Other

If Worker's Comp or Motor Vehicle-related:

Date of Accident: _____

Claim Number: _____

Contact Person: _____

Phone Number: _____

Insurance Information

Primary Insurance: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Policy Holder's ID or SSN:_____

Relationship to Patient: _____

Secondary Insurance:_____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Policy Holder's ID or SSN:_____

Relationship to Patient: _____

Emergency Contact Name: _____ Phone 1: _____

Relationship: _____ Phone 2: _____

Medical History Please check any that are applicable:				
	❑ AIDS/HIV	❑ Cardiac Condition	❑ High Blood Pressure	❑ Lupus
	❑ Allergies	❑ Diabetes	❑ Hypo/Hyperglycemia	❑ Mental Illness
	❑ Cancer	❑ Hearing Loss	❑ Pregnancy	❑ Multiple Sclerosis
	❑ COPD	❑ Hepatitis A B C	❑ Kidney Disease	❑ Seizures

Have you been treated by a Physical Therapist within the past 12 months? If so, please give details: _____

_____

Are you currently taking any medications? If so, please list: _____

Past Surgeries: _____

Have you ever broken any bones? If so, please list:_____

Have you ever been in a Motor Vehicle Accident? If so, when? _____

Do you participate in any sports or recreational activities? If so, please list:_____

_____

Please list your complaints in order of their importance:

1. _____ 2._____

_____

CONSENT FOR ASSESSMENT AND TREATMENT PROCEDURES

I HEREBY AUTHORIZE Physical Therapy Unlimited through its appropriate personnel to perform upon me or the above named patient such assessment and treatment procedures as are deemed necessary.

SIGNED: _____ DATE: _____

Physical Therapy Unlimited
Pain Rating Scale & Body Map

Name:_____ **Date:** _____

Write the number which best describes your pain at the present time, on your best day, over the past 30 days, and on your worst day.

Your Pain Rating:

	Your PAIN NOW
	On Your BEST DAY
	Over the PAST 30 DAYS
	On Your WORST DAY

Pain Scale:

10	Unbearable / Maximal
9	Very, Very Strong Pain
8	Very Strong Pain
7	Strong Pain
6	Somewhat Strong Pain
5	Moderate Pain
4	Mild Pain
3	Weak Pain
2	Very Weak Pain
1	No Pain At All

Please use these diagrams to indicate where your pain is located, and the symbols to describe the pain you feel.

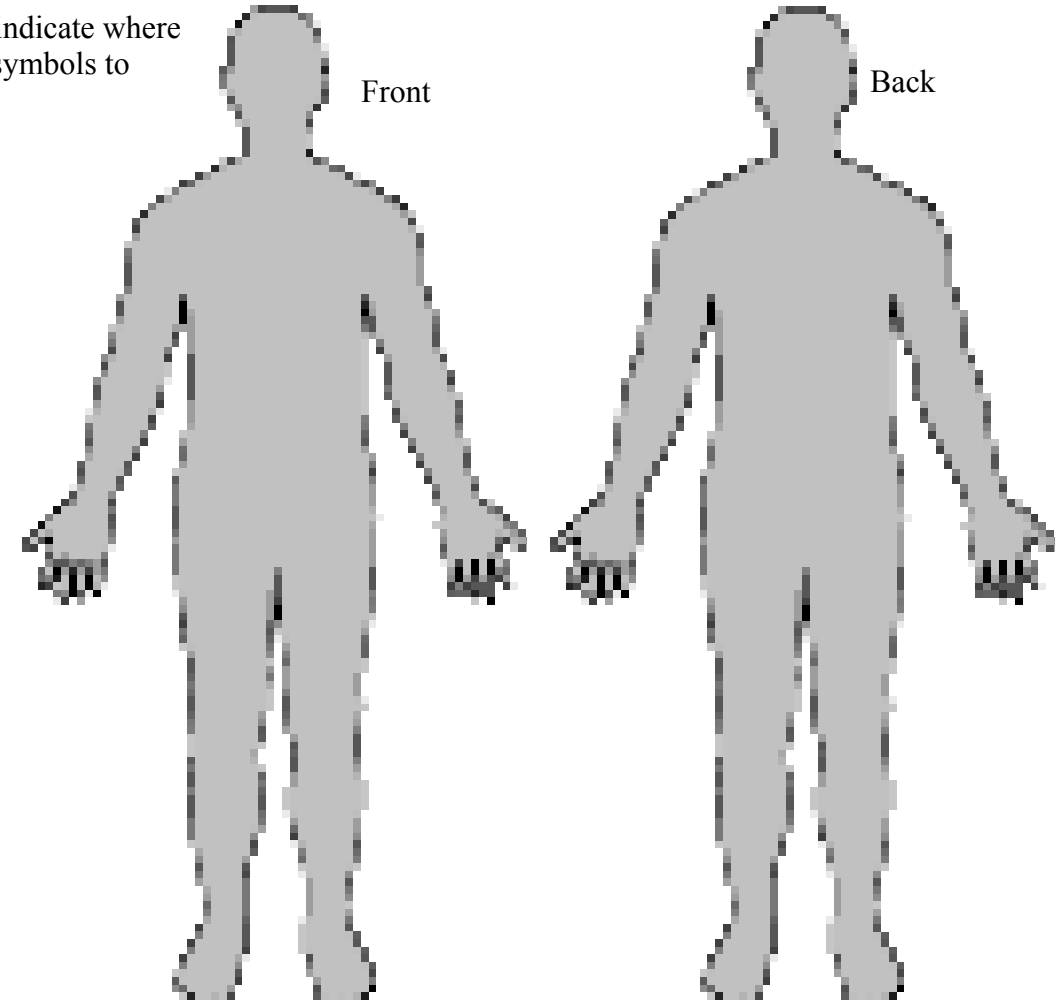
/ / / / Stabbing

* * * Aching

x x x Burning

+ + + Pins & Needles

= = = Numbness



Physical Therapy Unlimited

Attendance Policy:

Your Doctor and/or Physical Therapist have prescribed the frequency and duration of your visits. It is important to attend appointments as indicated in order to achieve your treatment goals. Our goal is to have you out of pain and functioning normally again. We appreciate your cooperation and look forward to working with you.

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- If you continue to experience pain, tell us so we can address it. If you are feeling better, please continue the course of treatment so we can help you prevent re-injury and help correct the cause of your condition.
- All of our therapists are trained professionals who maintain the high standards of Physical Therapy Unlimited. On occasion, you may need to see a therapist other than the one who normally treats you.

_____ _____ _____

Printed Name Signature Date

Cancellation Policy:

- We require **24 hours notice** in the event of a cancellation. It is your responsibility to reschedule cancelled appointments to ensure that your treatment is not compromised.
- There is a **$25 charge** for missed appointments that have not been cancelled within 24 hours. If you fail to show up for an appointment, you hurt yourself by missing a treatment, and you hurt another person who could have been scheduled for the appointment we reserved for you.

_____ _____ _____

Printed Name Signature Date

Acceptance of Financial Responsibility:

I understand that I am responsible for all copays, coinsurances, deductibles, or amounts not paid by my Insurance Company. Furthermore, I understand that I am responsible for obtaining referrals or pre-certifications for treatment from my Primary Care Physician or healthcare provider where required by my insurance plan.

_____ _____ _____

Printed Name Signature Date

SPINAL PATIENT

During the course of your treatment, it may be suggested that a spinal manipulation will reduce your pain and increase movement. Manipulation that is applied correctly and given after thorough examination and testing is regarded as a safe and effective form of treatment.

There have been documented cases where people have suffered strokes or other neurological damage as a result of spinal manipulation. In most of these cases, the manipulation technique had been poor and an insufficient examination was performed.

I have read and understood the above information and will allow manipulation to be a part of my treatment if deemed necessary.

Please ask any questions if further information is required.

_____ _____

PATIENT SIGNATURE DATE