LIFE FITNESS PHYSICAL THERAPY
MEDICAL HISTORY FORM

PATIENT NAME: _____ AGE: _____ TODAY'S DATE: _____
Occupation: _____ ARE YOU PRESENTLY WORKING? ☐N ☐Y – Full/Part Time
REFERRING PHYSICIAN'S NAME: _____ PRIMARY CARE PHYSICIAN'S NAME: _____
DATE OF NEXT MD APPT: _____ How did you hear about Life Fitness? ☐Doctor ☐Friend/Family ☐Advertisement ☐Ins Co
☐Other_____

WHAT IS YOUR REASON FOR ATTENDING THERAPY: _____

DATE OF INJURY/ONSET: _____CAUSE OF INJURY: _____
HAVE YOU HAD: ☐XRAY ☐MRI ☐ NERVE CONDUCTION TEST ☐BONE SCAN RESULTS_____

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

_____

_____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

_____

_____

Please rate your pain on the scale of 0 – 10 (0 = no pain… 10 = worst pain imaginable and need to go to the ER)

|––|––|––|––|––|––|––|––|––|––|––|
0 1 2 3 4 5 6 7 8 9 10

What best describes your pain? (circle all that apply)

Sharp Dull Achy Burning Radiating Stinging Nauseating Headaches Tingles Excruciating

Is the Pain: ☐Constant ☐Intermittent Is your Condition: ☐ Improving ☐Getting Worse ☐Not Changing

DESCRIBE YOUR GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR
DO YOU USE TOBACCO? ☐NO ☐YES - How Much? ____ packs/day ALCOHOL? ☐NO ☐YES – How Much? ____ drinks/day
HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? ☐NO ☐YES – When?_____
Why/What for?_____

HAVE YOU EVER HAD PHYSICAL THERAPY BEFORE? ☐NO ☐YES – what for?_____

- FOR THIS CONDITION? ☐NO ☐YES – where?_____
  WHAT WAS DONE/WHAT WERE THE RESULTS: _____
- THIS CALENDAR YEAR FOR ANY OTHER CONDITION? ☐NO ☐YES
  WAS IT RECEIVED AT: ☐HOSPITAL ☐OUT PATIENT CENTER ☐HOME HEALTH
  FOR HOW LONG? _____
- ARE YOU CURRENTLY RECEIVING HOME HEALTH SERVICES? ☐NO ☐YES

CURRENT MEDICATIONS: _____

ALLERGIES: ☐latex ☐lotions _____

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? (check all that apply):

☐ ANEMIA ☐ DEPRESSION ☐ RESPIRATORY PROBLEMS ☐ HEART PROBLEMS-what?_____
☐ ARTHRITIS ☐ DIABETES ☐ HIGH BLOOD PRESSURE ☐ HEPATITIS/HIV ☐ HEADACHES
☐ ASTHMA ☐ DIZZINESS/FAINTING ☐ KIDNEY PROBLEMS ☐ SEIZURES ☐ THYROID PROBLEMS
☐ CANCER- where?_____ ☐ LOW BLOOD PRESSURE ☐ FRACTURES ☐ SUBSTANCE ABUSE
☐ CURRENTLY PREGNANT ☐ PACEMAKER ☐ METAL IMPLANTS-where?_____
☐ ANY OTHER MEDICAL PROBLEMS: _____

SIGNATURE OF PATIENT: _____ REVIEWED BY PT: _____

LIFE FITNESS PHYSICAL THERAPY
PATIENT INTAKE AND CONSENT FORM

Date_____

First Name_____ Last Name_____ MI_____
Address_____ City_____ State_____ Zip_____
Home Phone#_____ Cell #_____ Work#_____
Email Address _____
Date of Birth_____ Age_____ Social Security #_____
Date of Injury/Onset_____ Sex: ☐Male ☐Female Marital Status: ☐S ☐M ☐D ☐ W
Occupation_____ Employer_____
Referring Physician_____ Primary Care Physician_____
Emergency Contact_____ Phone#_____
Auto-Related: ☐No ☐Yes Work Related: ☐No ☐Yes Attorney Involved: ☐No ☐Yes

Primary Insurance Information
Insurance Company_____ Policy#_____ Group#_____
Policy Holders Name_____ Relationship to patient_____
Policy Holders Employer_____ Policy Holders Phone#_____
Policy Holders SSN_____ Policy Holders DOB_____

Secondary Insurance / WComp / Auto Accident-PIP / Liability
Insurance Company_____ Policy#_____ Group#_____
Policy Holders Name_____ Relationship to patient_____
Policy Holders Employer_____ Policy Holders Phone#_____
Policy Holders SSN_____ Policy Holders DOB_____
Adjustors Name_____ Adjustor's Phone#_____
Attorneys Name_____ Attorney Phone #_____

Please Initial

Consent to Treatment: I consent to rehabilitation and related services at Life Fitness PT. In doing so, I understand, acknowledge and affirm that such rehab and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. _____

Treatment of Minors: I, as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premise during any such treatment, and waive any claim I may have resulting from failure to do so. _____

Liability: I know and agree that Life Fitness PT is not responsible for loss or damage to person valuables _____

Waiver and Release: I hereby release, discharge, and acquit Life Fitness PT, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive, or allow emergency and or medical services, including but not limited ambulance service, Emergency Medical Technician, physician, or urgent care services. _____

Authorization of Payment: I hereby assign all benefits directly to Life Fitness PT and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice Of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. _____

Notice of Privacy: I acknowledge receipt of Notice of Privacy Practices. _____

I certify that all the above information provided herein is true and correct. I hereby, authorize and instruct my insurance carrier to pay Life Fitness PT directly for any physical therapy services performed. Additionally, I understand that I am financially responsible for payment of all co-pays, deductibles and balances not covered by my insurance carrier, provided my specific plan does normally pay for the services and/or products rendered to me by the medical providers at this facility. If I cancel or do not show for an appointment within 24 hours of the appointment date, I understand that I may be charged a $30 fee. In the event an outstanding balance is referred to an attorney for collection, I will be responsible for all costs of collection to include but not limited to litigation expenses, court costs, service of process fees and attorney's fees not to exceed twenty (20%) percent of the outstanding balance. I also waive the right to claim statue of limitations as a defense in any collection action and that any outstanding balance may accrue interest at a rate of eighteen (18%) percent per annum.

Patient/Guardian Signature_____ **Witness Signature**_____