positiveenergy
Physical Therapy | Sports Performance

(ALL INFORMATION ON THIS FORM IS CONFIDENTIAL.)

CLIENT INFORMATION

Today's date: _____

Name: _____ ☐ Male ☐ Female
First MI Last

Address: _____
Street Address City State Zip Code

Primary phone: _____-_____-_____ ☐ Cell ☐ Home ☐ Work Email address: _____

Date of birth: _____

Emergency contact: _____ Phone: _____-_____-_____ Relationship _____

AUTHORIZATION FOR TREATMENT

I hereby consent to and authorize all therapy treatments, which in conjunction with the judgment of my attending physician, may be considered necessary and/or advisable for the diagnosis and/or treatment of the patient named above at Positive Energy.

Signature: _____ Date: _____
(Parent or Legal Guardian must sign if client is under 18 years of age)

Relationship to client: ☐ Mother ☐ Father ☐ Legal Guardian

FINANCIAL POLICY AND INSURANCE INFORMATION:

Please check one box and sign.

☐ **FOR CLIENTS WHO WOULD LIKE TO USE THEIR HEALTH INSURANCE POLICY:**
I would like to use my health insurance and I agree that my insurance provider will be billed for services provided while attending physical therapy. I hereby give authorization for my insurance provider to pay Positive Energy directly. In the event my insurance company pays me directly, I will immediately deliver payment to Positive Energy. If my insurance provider does not pay for services, I am responsible and liable for payment to Positive Energy.

☐ **FOR CLIENTS WHO ARE NOT USING THEIR HEALTH INSURANCE POLICY:**
In lieu of using my health insurance, I will provide payment to Positive Energy.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand the notice of privacy practices is available for me to review at www.positiveenergypt.com. Additionally, a copy of the notice will be provided upon request.

Signature: _____ Date: _____

APPOINTMENT CANCELLATION AND NO-SHOW POLICY

Please provide us with at least 6 hours notice for cancellations or changes. Cancellations made less than 6 hours in advance will result in a $50 charge. A no-show will result in a $100 charge.

Signature: _____ Date: _____

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Height: _____ **Weight:** _____

MEDICAL HISTORY: (Existing or relevant previous conditions.)

Allergies	❑ Yes	❑ No	Dizzy Spells	❑ Yes	❑ No	MRSA	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Emphysema/Bronchitis	❑ Yes	❑ No	Multiple Sclerosis	❑ Yes	❑ No
Anxiety	❑ Yes	❑ No	Fibromyalgia	❑ Yes	❑ No	Muscular Disease	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Fractures	❑ Yes	❑ No	Osteoporosis	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Gallbladder Problems	❑ Yes	❑ No	Parkinson's	❑ Yes	❑ No
Autoimmune Disorder	❑ Yes	❑ No	Headaches	❑ Yes	❑ No	Rheumatoid Arthritis	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Hearing Impairment	❑ Yes	❑ No	Seizures	❑ Yes	❑ No
Cardiac Conditions	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No	Smoking	❑ Yes	❑ No
Cardiac Pacemaker	❑ Yes	❑ No	High Cholesterol	❑ Yes	❑ No	Speech Problems	❑ Yes	❑ No
Chemical Dependency	❑ Yes	❑ No	High/Low Blood Pressure	❑ Yes	❑ No	Strokes	❑ Yes	❑ No
Circulation Problems	❑ Yes	❑ No	HIV/AIDS	❑ Yes	❑ No	Thyroid Disease	❑ Yes	❑ No
Currently Pregnant	❑ Yes	❑ No	Incontinence	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Depression	❑ Yes	❑ No	Kidney problems	❑ Yes	❑ No	Vision Problems	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Metal Implants	❑ Yes	❑ No			

Describe any other conditions or precautions: _____

_____

_____

_____

_____

Fall History

Injury as a result of a fall in the past year? ❑ Yes ❑ No Date of Fall: _____

Two or more falls in the last year? ❑ Yes ❑ No Dates of Falls: _____

Surgical History (If greater than three, please provide us with a list.)

Body Region:_____ Surgery Type: _____ Date of Surgery: _____

Body Region:_____ Surgery Type: _____ Date of Surgery: _____

Body Region:_____ Surgery Type: _____ Date of Surgery: _____

Current Medications (If greater than three, please provide us with a list.)

Drug:_____ Dosage: _____ Reason for Taking:_____

Drug:_____ Dosage: _____ Reason for Taking:_____

Drug:_____ Dosage: _____ Reason for Taking:_____

❑ Currently not taking any medications.

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(ALL INFORMATION ON THIS FORM IS CONFIDENTIAL.)

1. Circle a value on the pain intensity scale that best describes your pain at its worst.
2. Shade the location of your pain on the body diagrams below.

PAIN INTENSITY	PAIN LOCATION

10 Pain as bad as it could be

9 Excruciating

8

7 Severe

6

5 Moderate

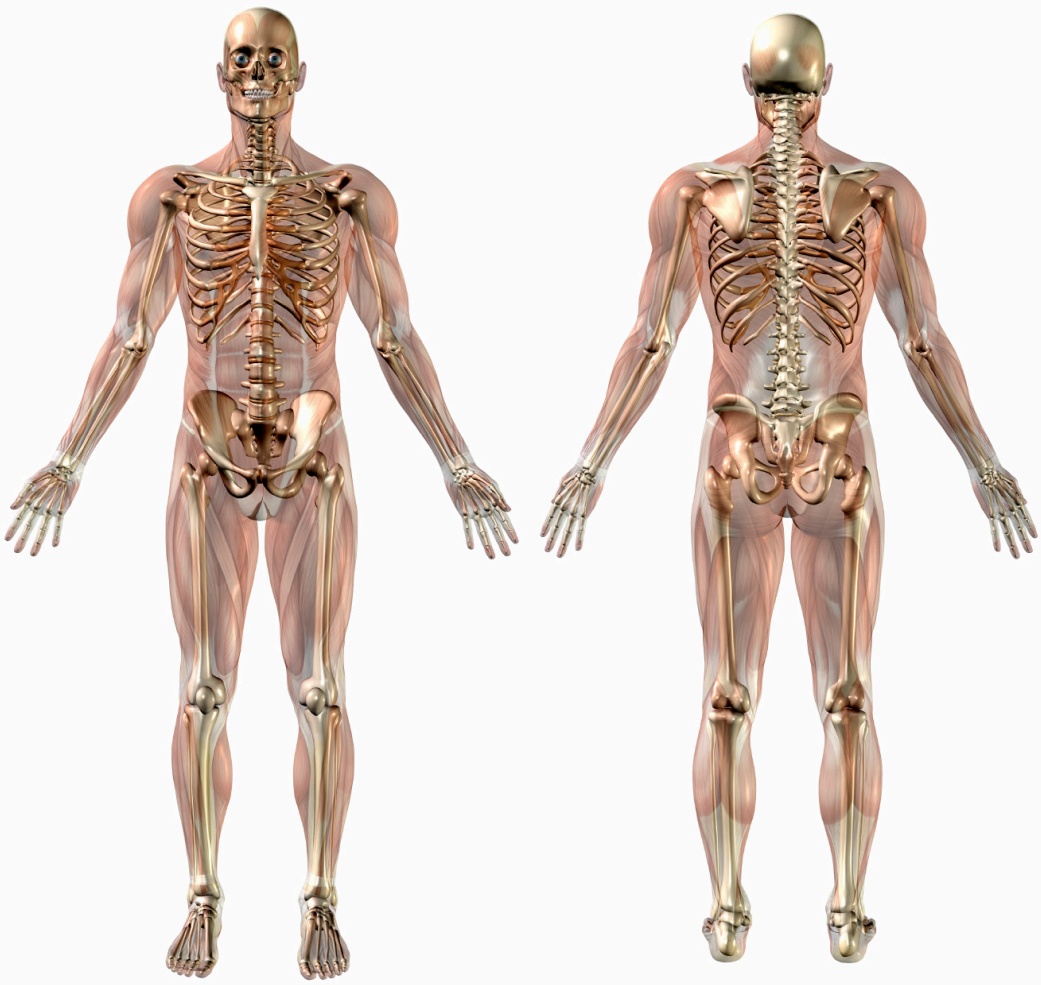
4

3 Mild

2 Slight

1

0 No Pain



Is there anything else you would like your physical therapist to know? If so, please explain.

_____

_____

_____

_____

_____

_____