

Name: _____ Date: _____

Leisure activities, including exercise routines: _____

Occupation, including activities that comprise your workday: _____

Age: _____ Height: _____ Weight: _____

Are you latex sensitive? YES NO Do you smoke? YES NO

Do you have a pacemaker? YES NO Do you have hearing loss? YES NO

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following (check all that apply)?

- | | |
|--|---|
| <input type="checkbox"/> fatigue | <input type="checkbox"/> numbness or tingling |
| <input type="checkbox"/> fever/chills/sweats | <input type="checkbox"/> muscle weakness |
| <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> dizziness/lightheadedness |
| <input type="checkbox"/> weight loss/gain | <input type="checkbox"/> heartburn/indigestion |
| <input type="checkbox"/> constipation | <input type="checkbox"/> fainting |
| <input type="checkbox"/> headaches | <input type="checkbox"/> changes in bowel or bladder function |
| <input type="checkbox"/> difficulty maintaining balance while walking | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> falls | |

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|--|--|--|
| <input type="checkbox"/> cancer | <input type="checkbox"/> depression | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> lung problems | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> chest pain/angina | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> asthma | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> circulation problems | <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> other arthritic condition | <input type="checkbox"/> eye problem/infection |
| <input type="checkbox"/> stroke/ head injury | <input type="checkbox"/> bladder/urinary tract infection | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> anemia | <input type="checkbox"/> kidney problem/infection | <input type="checkbox"/> liver problems |
| <input type="checkbox"/> bone or joint infection | <input type="checkbox"/> sexually transmitted disease/HIV | |
| <input type="checkbox"/> chemical dependency (i.e., alcoholism) | <input type="checkbox"/> pneumonia | |
| <input type="checkbox"/> pelvic inflammatory disease | | |

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

During the past month have you been bothered by having little interest or pleasure in doing things?

YES NO

Is this something with which you would like help? YES YES, BUT NOT TODAY NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|--|-------------------------------------|---|
| <input type="checkbox"/> cancer | <input type="checkbox"/> diabetes | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> stroke | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> depression | <input type="checkbox"/> blood clots |

Please list all medications you are currently taking: (including dosages and frequency):

- | | | |
|-------------------------------------|-------------------------------|---|
| -Blood Pressure Medication _____ | -Heart Medication _____ | -Anti-coagulants (blood thinners) _____ |
| -Muscle Relaxants _____ | -Pain Killers _____ | -Diabetes Medication (i.e. insulin) _____ |
| -Steroids _____ | -Anti-inflammatories _____ | -Other Medications (state condition) _____ |

Have you ever taken steroid medications for any medical conditions? YES NO

Have you ever taken blood thinning or anticoagulant medications for any medical conditions?

YES NO

Please List all surgeries you have had (include dates): _____

What date (roughly) did your present symptoms start? _____

What do you think caused your symptoms? _____

My symptoms are currently: Getting Better Getting Worse Staying about the same

Treatment received so far for this problem (chiropractic, injections, etc)

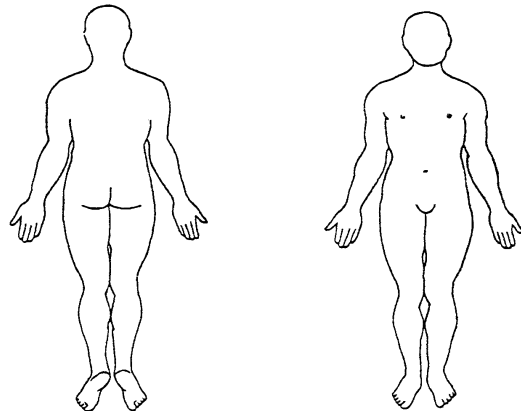
Please list special tests performed for this problem (x-ray, MRI, labs, etc)

Have you ever had this problem before: Yes No When _____ Treatment rec'd

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

- ↓ **Shooting/sharp pain**
- **Dull/aching pain**
- ||| **Numbness**
- = **Tingling**



My symptoms currently: Come and go Are Constant Are constant, but change with activity

Aggravating Factors: Identify important positions or activities that make your symptoms worse:



Easing Factors: Identify important positions or activities that make your symptoms better:

How are you currently able to sleep at night due to your symptoms?

No problem sleeping Difficulty falling asleep Awakened by pain Sleep only with medication

When are your symptoms worst? Morning Afternoon Evening Night After exercise

When are your symptoms the best? Morning Afternoon Evening Night After exercise

Using the 0 to 10 the scale, with 0 being “no pain” and 10 being the “worst pain imaginable” please describe:

Your current level of pain while completing this survey: _____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____

I certify that the above information is accurate to the best of my knowledge.

Patient Signature

Date

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.
3. 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.
4. 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.
5. Worker's Compensation - I hereby authorize Pappas Physical and Hand Therapy to receive my records related to my work injury.

Patient Signature

Date



Photo/Video Authorization

I grant to Pappas Physical and Hand 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/occupational 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.

Agree or Decline

Notice of Privacy Practices

By signing this form, I acknowledge that Pappas Physical and Hand 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 Pappas Physical and Hand Therapy Specialists representatives.

Patient Signature

Date

PT/OT Benefits Provided by Your Insurance Company

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 Pappas Physical and Hand 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 VISIT WITH TREATMENT \$ _____
FOLLOW UP VISITS \$ _____
DEDUCTIBLE \$ _____

Communication: I authorize PPHT to communicate with me via email and/or Text message.



YES NO

EMAIL: _____

PHONE: _____

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 consent form. By signing this form, I am acknowledging my understanding of the "Notice of Privacy Practices" and authorizing persons listed on the Information Release to receive my health information.

Patient or Guardian Signature

Date