Patient Application

First Name: ________________ M.I.: _____ Last Name:______________________ Date: _____ /_____ /_____
Address: ____
City: ____________________ State: ______ Zip: ________
Gender: M / F Age: _____ DOB: ___ /___ / ___ SS#: _____-_____-______
Email Address: ____
Home #:__________________ Cell #_________________ Work#_______________

Occupation: ____
Employer Name: ____

Marital Status: ____________________ Spouse's Name: ___________________________
Spouse's Occupation/Employer: _______________________ Cell#: ___________________
How Many Children Do You Have? ______ Children's Ages: _________________
Emergency Contact Name:_________________________ Phone #:__________________

How Did You Hear About This Office?
☐ Existing Patient: __________________________ ☐ Insurance Company Website: ______________
☐ Facebook / Google: ______________________ ☐ Walk-In/Drive-By__________________________
☐ CrossFit: ________________________________ ☐ Community Event: ________________________
☐ Other: _________________________________

What Medications Are You Currently Taking? ____
What Supplements Are You Currently Taking? ____

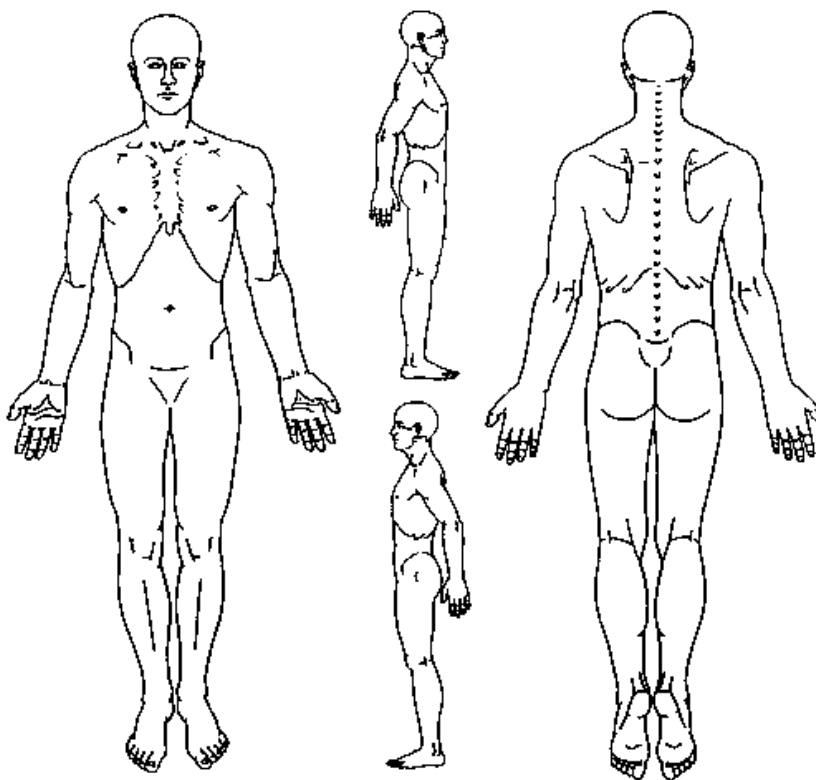
Do You Exercise? ☐ Yes ☐ No What Activities? How Often? ____________________________________
Do You Smoke? ☐ Yes ☐ No How Much? / How Often? ____
Do You Drink Alcohol? ☐ Yes ☐ No How Much? / How Often? _____________________________________
Do You Drink Coffee? ☐ Yes ☐ No How Much? / How Often? ______________________________________
Do You Have Any Allergies? (specify) ____
Are You Pregnant? ☐ Yes ☐ No Date of Last Menstrual Period? ____ /____ /____

I Have: ☐ Never Received Treatment For This Problem ☐ Been Seen By another Physical Therapist
☐ Been Seen By another Doctor ☐ Been Hospitalized
Have You Ever Received Physical Therapy? ☐ Yes ☐ No Purpose of Visit(s):______________________
Last Visit? _______________ Physical Therapist/Office Name:______________________________________
How Long Did You Receive Treatment?__________________
Did You Perform Rehabilitation Exercises at Home? ☐ Yes ☐ No
What Surgeries Have You Had? ____
List Any Recent Accidents or Falls: ____

Purpose for This Visit? ____
How Long Have You Been Suffering from this Problem? ______________________________
On A Scale of 1 to 10, How Severe is it at its Worst? 1 2 3 4 5 6 7 8 9 10
What Makes It Feel Worse? ____
What Makes It Feel Better? ____
When Do You Notice It Most? (circle) Morning Afternoon Evening
What % of the Day Do You Experience It? 0 10 20 30 40 50 60 70 80 90 100

On the diagram below, please label ALL areas you are experiencing symptoms as it relates to the purpose of your visit today using the appropriate letter from the box below.

A=Aching	**C=Cramping**	**R=Throbbing Pain**	**N=Numbness**	**O=Other**
B=Burning	**D=Dull Pain**	**S=Stiffness**	**T=Tingling**	



Health Conditions

Mark with an "X" Current Symptoms and "O" Past Symptoms

___ Neck Pain
___ Pain in Shoulders/Arms/ Hands
___ Numbness/Tingling in Hands
___ Coldness in Hands
___ Weakness of Grip
___ Headaches/ Migraines
___ Fatigue/ Low Energy
___ Thyroid Problems
___ Allergies/ Sinus
___ TMJ Pain
___ Visual Disturbances
___ Hearing Disturbances
___ Dizziness/ Loss of Balance
___ Ear Infections
___ Fainting
___ Epilepsy
___ ADD/ADHD
___ Depression
___ Upper/Mid Back Pain
___ Pain in Ribs/Chest
___ Heartburn/Indigestion
___ Nausea
___ Reflux
___ Ulcers/Gastritis
___ Shortness of Breath
___ Asthma/Wheezing
___ High/Low Blood Pressure
___ Heart Palpitations
___ Heart Murmurs
___ Tachycardia
___ Pacemaker
___ Heart Attack
___ Stroke
___ Diabetes
___ Cancer
___ Hypoglycemia
___ Hyperglycemia
___ Pain with Cough/Sneeze
___ Low Back Pain
___ Pain in Hips/Legs/Feet
___ Numbness/Tingling in Legs / Feet
___ Coldness in Feet
___ Weakness in Legs
___ Frequent/Difficulty Urinating
___ Diarrhea/Constipation
___ Kidney Problems
___ Prostate Problems
___ Sexual Dysfunction
___ Menstrual Irregularities
___ Menopausal Problems
___ Trouble Sleeping
___ Trouble Concentrating
___ Traumas/Car Accidents (Please List):
____
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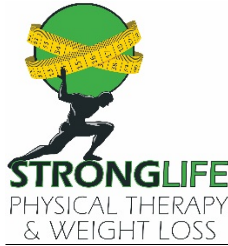

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Informed Consent for Physical Therapy Services

Physical Therapy: The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation and intervention by use of rehabilitative procedures, mobilization, manual techniques, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to me before they are performed.

Informed Consent for Treatment: The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. I understand that the physical therapist provides a wide range of services and I will receive information at the initial visit concerning the treatment and options available for my condition.

I will notify my practitioner if I am pregnant, become pregnant, or am trying to get pregnant. I understand I am encouraged to communicate with a physician the potential benefits and risks of treatment relevant to my pregnancy.

Potential Benefits: Benefits may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the recourses available to me.

Potential Risks: I may experience an increase in my current level of pain or discomfort, or aggravation of my existing injury during physical therapy. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

No Warranty: I understand that my physical therapist cannot make any promises or guarantees regarding **a** cure for or improvements in my condition. I understand that my physical therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Insurance: I, the patient, am ultimately responsible for payment of my account. As a courtesy, Stronglife Physical Therapy & Weight Loss will bill my insurance company on my behalf. I am responsible for paying any deductible and/or co-payment due at time of service. After 60 days any balance not paid by insurance will become my responsibility.

I may elect to pay out of pocket for physical therapy services. For patients without insurance or for those who elect to pay out of pocket, **a** discounted "cash rate" of $125 for the initial evaluation and $75 for follow-up appointments will apply. Payment will be due at the time of service.

Cancellation Policy In the event that I need to cancel a scheduled appointment, I agree to provide the courtesy of 24-hours notice so that Stronglife PT can offer my appointment to patients waiting on the standby list. If I fail to give 24-hours notice of **a** cancellation, I understand that I will be subject to a $25 missed appointment fee.

I have read the above information and I consent to physical therapy evaluation and treatment. My signature below acknowledges that I have read, understood and will abide by the conditions and policies noted on this consent form.

Print name of patient Date

Patient's signature (if patient is a minor, parent or legal guardian must sign)