PREMIUM PHYSICAL THERAPY
2021 Herndon Ave. Suite 202, Clovis, CA 93611
Phone: 559-321-8405 Fax: 559-900-7952

PATIENT INFORMATION

Patient Name: _____ _____
Last First MI Preferred Name

Street Address:_____ City:_____ State:_____ ZIP: _____

Phone:_____ home/mobile (please circle one)

Emergency Contact Name : _____Phone: _____
Spouse/Family/Other (please circle one)

Date of Birth: ___ /__/__/___ Sex: Male/Female Marital Status: □ Single □ Married □ Divorced □ Widowed
Mo Day Year

Social Security Number: _____ -___-_____ Email Address: _____

Employer/School:_____ Phone: _____

Primary Care Physician:_____ *If different from referring Doctor may we release records? □ Yes □ No*

Other healthcare providers you have seen for your present condition:

_____ _____
Provider's Full Name Provider's Full Name

How did you hear about us? Please circle one and write a response.

Social Media: Which one? _____

Internet Search: Google Yahoo Yelp Other: _____

What key words did you type in?_____

Word of mouth: Friend Relative Acquaintance Other: _____

Other Website: Which site?_____

MD Referral: _____

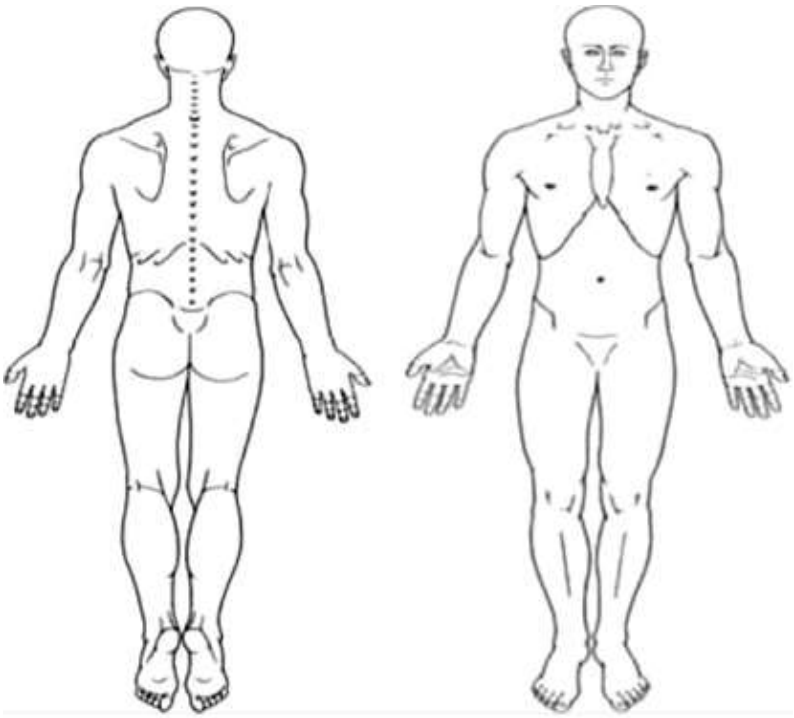
Other: _____

PAIN AND SYMPTOM STATUS REPORT

Using the symbols below, please draw at the location on the body outlines using the type of pain key chart you are experiencing.

Pain Key

Numbness: O O O O
Pins & Needles: □ □ □ □
Stabbing: / / / / / /
Ache: **M M M M**
Burning: **X X X X**



CHIEF COMPLAINT AND VISUAL ANALOG SCALE

My chief complaint is: _____

_____

Body Part:_____ Date first symptom of your problem occurred on: ____ /____ /_____

How did your problem occur:_____

Please list any previous injuries:

Injury	Treatment	Date
_____	_____	_____
_____	_____	_____

Please circle on the scale below to indicate your ***worst*** level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets

Please circle on the scale below to indicate your ***current*** level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets

Please circle on the scale below to indicate your ***least*** level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets

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GENERAL MEDICAL HISTORY

Studies you have had so far for your present problem:

Test: Location: Date:

□ X-Rays
□ CT/MRI Scan

Treatments:

□ Anti-inflammatories □ Hot/Ice packs □ Acupuncture □ Physical therapy
□ Muscle relaxers □ Massage Therapy □ Facet injections □ Orthotics
□ Pain Relievers □ Epidural injections □ Chiropractic □ Electrical stimulation

Please circle or list other health conditions that you are currently being treated for:

Cardiovascular: Pace Maker Hypertension Myocardial infarction DVT
Respiratory: Asthma Pulmonary embolus COPD Thrombophlebitis
Gastrointestinal: Ulcers _____
Neurological: CVA _____
Endocrine: Diabetes _____

Do you smoke cigarettes, cigars or pipes? □ Yes □ No *If yes, how many times per day?* _____
Do you drink alcohol? □ Yes □ No *If yes, how many times per day?* _____

Please list all medications (including non-prescription) that you are currently taking:

Medication	Dosage	Frequency

Please list any allergies that you currently have and the reaction that occurs: _____

_____

Please list any surgical procedures you have had:

_____ _____ _____ _____
Surgery Surgeon Hospital Date

_____ _____ _____ _____
Surgery Surgeon Hospital Date

Systems Review:

What is your current height and weight? _____feet _____inches _____lbs
Have you lost or gained weight in the past year? □ Yes □ No *If yes, lost or gain? (**circle one**)*_____lb
Do you have seizures? □ Yes □ No
Do you have problems with shortness of breath? □ Yes □ No
Do you have chest pain? □ Yes □ No
Do you have history of cancer? □ Yes □ No
Was this injury a result of an accident on the job? □ Yes □ No
Was this injury a result of a motor vehicle accident? □ Yes □ No

CONSENT FOR TREATMENT

My signature is required below to authorize treatment by Premium Physical Therapy. I am aware of my diagnosis and voluntarily consent to treatment at this practice. I agree to the service rendered and will cooperate in giving any information needed for treatment.

_____ _____

Signature Date

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

I hereby consent to the use and disclosure of my personal health information for the purpose of treatment, payment, and healthcare operation. I also grant permission for this practice and it's affiliates to obtain information from my physician and other medical professionals as it relates to my treatments.

_____ _____

Signature Date

POLICY DISCLOSURE

I hereby authorize the facility to accept assignment of insurance benefits and I understand that I am responsible for coinsurance, co-payments, and/or deductibles at the time of service. I understand that if my insurance is a non-contracted plan (out of network); the facility will courtesy file the claim for services rendered. In the event that I have no insurance coverage, I understand that the fees are due at the time of service. I understand that the previous balances owed to the facility will be requested at the time of registration. **The patient is ultimately responsible for any balance that is not paid by insurance.**

_____ _____

Signature Date

Please provide us with at least 24 hours notice should you need to reschedule or cancel an appointment, otherwise you may be billed a charge of $25.00. Patients that arrive 15 minutes or more late may be asked to reschedule their appointment. *Initial*: _____

A storage area is available to our patients during their visit. We are not able to accept liability for any personal items brought to the clinic. We are a smoke and drug free environment. *Initial*: _____

I authorize Premium Physical Therapy to send text messages to my mobile phone for appointment reminders. I understand that standard messaging rates may apply and that I may opt out at any time by replying “OPT OUT.” Initial: _____

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A copy of the Notice of Privacy Practices (NPP) is available to all patients. This NPP identifies: 1) How medical information may be used or disclosed; 2) Your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our use and disclosures of that information; 3) Your rights to complain if you believe you privacy rights have been violated; and 4) Our responsibilities for maintaining your privacy as your medical representative.

If you have any questions regarding this notice or would like to exercise any of your rights under this notice, you may contact: (559) 321-8405

You have the right to request a copy of the facility's Notice of Privacy Practices, Patients Rights and Responsibilities, and the Patient Payment Policy. I further acknowledge that a copy of the current notice is posted in the reception area.

_____ _____

Signature Date

_____

Print Name