CONFIDENTIAL MEDICAL HISTORY / EVALUATION

Name _____ **Date of Birth** _____/ _____ /_____ **SS#**_____

Address _____**City** _____ **State** _____ **Zip** _____

Home phone # _____ **Cell #** _____ **Work #** _____

E-Mail Address_____ **How did you hear about us?**_____

May we leave a message at your home? (circle) Yes / No On Cell? Yes / No At work? (circle) Yes / No Male / Female

Your employer _____ **Street Address**_____

City _____ **State**_____ **Zip** _____ **Is this injury work related? Yes / No Auto Accident? Yes / No**

Are you currently receiving home health care? (circle) Yes / No Do you reside in a nursing home? (circle) Yes / No

Have you received Occupational or Physical Therapy this year? (circle) Yes / No If yes, how many visits? _____

Body Part Affected_____ **Date of Injury/Onset** _____ **Date of Surgery (if applicable)**_____

Current Symptoms (circle): Pain / Numbness / Stiffness / Weakness Is this condition (circle): New / Acute / Chronic

Are you allergic to any medications? _____ **Allergic to Latex? Yes / No**

List any surgeries _____ **Referring Doctor** _____**Phone #**_____

May we send a report to your Primary Care Physician? Yes / No If yes, name of doctor _____

Have you had any Diagnostic or Rehabilitative services for this injury? (circle) MRI X-Rays Other

Have you had any of the following? Please circle all that apply

Infectious Disease	**Yes**	**No**	**Asthma**	**Yes**	**No**
Bronchitis	**Yes**	**No**	**Emphysema**	**Yes**	**No**
Shortness of Breath	**Yes**	**No**	**Coronary Heart Disease**	**Yes**	**No**
Do you have a pacemaker?	**Yes**	**No**	**High Blood Pressure**	**Yes**	**No**
Heart Attack	**Yes**	**No**	**TIA / Stroke**	**Yes**	**No**
Blood Clot / Embolism	**Yes**	**No**	**Epilepsy / Seizure**	**Yes**	**No**
Dizziness or Faintness	**Yes**	**No**	**Osteoarthritis**	**Yes**	**No**
Diabetes	**Yes**	**No**	**Rheumatoid Arthritis**	**Yes**	**No**
Cancer or Chemo/Radiation	**Yes**	**No**	**Gout**	**Yes**	**No**
Swollen Joints	**Yes**	**No**	**Sleeping Difficulties**	**Yes**	**No**
Osteoporosis	**Yes**	**No**	**Vision Difficulties**	**Yes**	**No**
Emotional / Psychological Problems	**Yes**	**No**	**Hearing Difficulties**	**Yes**	**No**
Are you pregnant?	**Yes**	**No**	**Smoking**	**Yes**	**No**
How many falls have you taken within the last year without injury?_____			**Smokeless Tobacco**	**Yes**	**No**
How many falls have you taken within the last year with injury?_____			**Do you feel safe at home?**	**Yes**	**No**

Have you been threatened or injured by anyone? Yes No

Other Medical Conditions: _____

Please list the following if applicable:

Medication	Dose	Route (circle method)	Frequency
		Oral Injection Topical	
		Oral Injection Topical	
		Oral Injection Topical	
		Oral Injection Topical	
		Oral Injection Topical	

PATIENT MISSED APPOINTMENT POLICY

Our Mission at Hands-On Physical Therapy Specialists is to help you get back to doing whatever it is that you've been missing: We want to help you get better! ***We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.*** Your commitment to your home program and therapy schedule is imperative in order for you to achieve the best results possible. ***Adhering to your therapy schedule is a vital factor to achieve the successful results we all want.*** Our commitment to your wellbeing and improvement of your physical abilities is something that everyone in our clinic takes quite seriously. **Therefore, our therapists see patients on an individual basis. We do not double book our therapists; you have exclusive time with your therapist at each of your therapy sessions.**

Due to this, we have a policy that needs to be followed in order to ensure the most optimum results. **With the exception of serious emergencies, it is expected that you keep all of your appointments**. If you need to re-schedule an appointment, **we require 24 hours notice**. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferably the very next day for the continuity of your care. In instances of repeated non-compliance with your scheduled visits, we reserve the right to discontinue care. In this case, we will inform your physician (and case manager for those with work injuries) of the fact that your therapy has been discontinued due to non-compliance with the prescribed rehabilitation order.

A $50 fee will be charged for cancellations without 24 hours notice or if you do not show up to a scheduled appointment A Monday appointment must be cancelled the previous Friday.

For Worker's Compensation Patients: we must report your attendance and progress to your physician and Case Manager or Third Party Administrator. Unexcused absences can, in some cases, terminate your worker's compensation benefits.

I hereby authorize treatment by Hands-On Physical Therapy Specialists. I request that payment of authorized insurance benefits be made to Hands-On Physical Therapy Specialists for any services furnished to me by them. I understand that if I do not have a necessary referral from my PCP or authorization from my insurance company, I will be held responsible for payment. Furthermore, I understand that Hands-On Physical Therapy Specialists will bill by insurance company and I am responsible for the prompt and full payment of any co-payments, deductibles, co-insurance and supplies that may apply or are not covered by my insurance. I also authorize Hands-On Physical Therapy Specialists to release to my insurance company and its agents, any information needed to determine these benefits or the benefits payable for related services or to facilitate the delivery of medical services. If my insurance company does not make payment, my insurance is terminated, or I do not have insurance, I understand that I am fully responsible for any and all charges resulting from my therapy and or supplies and equipment I receive during my therapy. If my account requires the services of a collection agency, I understand that there will be an additional $20 charge for transference of the account to collections.

Emergency Contact Name _____ **Phone #** _____ **Relationship** _____

To whom may we release/discuss information about your care (names)_____

_____

I acknowledge that I was offered a copy of the "Notice of Privacy Practices". (Please initial) _____

I acknowledge the above is true and correct, and additionally have read and understand the Patient Missed Appointment Policy.

Patient Signature (Parent or Guardian, if minor) _____ **Date** _____