PROGRESSIVE MOTION PHYSIOTHERAPY

3475 EDISON WAY, SUITE H, MENLO PARK, CA 94025

Last_____First_____Middle Initial___
Nickname/Preferred Name _____
Parent Name (if under 18)_____
Date of Birth: (MM/DD/YYYY) _____/_____/_____ Age _____
Driver's License # _____
Phone _____ (is this cell/home/office?) _____
Email _____ Address_____
Your preferred method of contact method: (Phone, Email, Text) _____
What is the earliest _____ and latest _____time you will accept phone calls?
Is it okay to send personal health information to your email address (Yes/No)? _____
Is it okay to leave personal health information on your phone voice mail (Yes/No)? _____

Please complete all that applies - Employer Name and City:_____
School Name and City: _____
Sport/Dance Team: _____

Health Information:

Primary Physician: _____Phone_____
Specialist Physician:_____ Phone _____
In general, how is your overall health over the past year? Excellent, Very Good, Good, Fair, Poor?_____

Please list of all of your medications:

_____

Are you being treated for a work related injury(Yes/No)? _____
Are you being treated for an injury caused by an auto accident (Yes/No)?_____
Is there an attorney for this accident/injury (Yes/No)?_____

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DR.JOEY@PMPT14.COM
650.517.3639

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Please place a checkmark if you have history of any of the following:

Heart Problems	Stroke	Lung issues	Asthma	Seizures	Diabetes
Pacemaker	Hypertension	Blood Clotting disorder	Kidney Disease	Tuberculosis	Thyroid Issues
Cancer	Sudden Weight loss Or gain	Night fever, Chills, sweat	Nausea Or vomiting	Osteoporosis Or osteopenia	Osteoarthritis
Rheumatoid Arthritis	Headaches	Mental Illness	Numbness/ Tingling	Bowel Or bladder Issues	Pelvic pain
HIV/AIDS	hepatitis	Chemical or Alcohol Dependency	Depression	Anxiety	Eating Disorder
Sensitive skin	allergies				

Answer Yes, No, N/A:

Do you smoke _____
Have you started menstruating? ____
Are you pregnant?_____
Do you feel safe at home?_____ Do you feel safe at school?_____
Do you feel safe with your recreational teams/groups?_____

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Sign here to indicate that the information provided above is accurate. Additionally, any of the above information or information gathered during physical therapy treatments can be shared with the physicians listed above.

Patient/Client Signature_____Date_____
Parent Signature (if under 18) _____Date_____
Print Parent Name_____

By signing here, you have legal rights to make medical decisions for this child

Pain at LOWEST: Rate you lowest pain level in past 24 hrs.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

Pain Currently: Rate your level of pain at this time.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

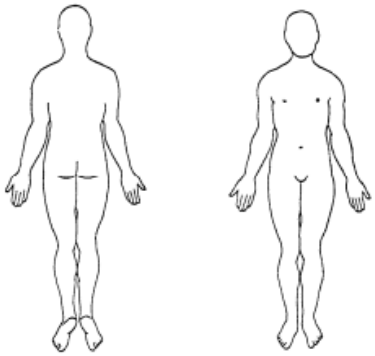
Pain at WORST: Rate your highest pain level in past 24 hrs.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

Body Chart:

Please mark the location of your pain and type of pain on the chart:

Key:
X sharp stabbing pain
O Dull achy pain
….Numb/Tingling
/// Throbbing
=== Burning



Please list any other musculoskeletal injuries/surgeries in the past and please include dates: _____

_____

What activities make your current symptoms feel worse? _____

_____

What activities make your current symptoms feel better?_____

_____

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What are the goals you would love to achieve for physical therapy? _____

_____

Who is part of your health care team?

Do you have a Naturopathic MD?	**YES**	**NO**
Do you have a dentist?	**YES**	**NO**
Do you have a psychologist?	**YES**	**NO**
Do you have a trainer?	**YES**	**NO**
Do you have a chiropractor?	**YES**	**NO**

Progressive Motion Physical Therapy -- PATIENT POLICIES effective 07/1/2014 - PLEASE READ AND SIGN AFTER EACH STATEMENT

Payment Authorization and Patient Responsibility Initial each line:

____**Insurance:** We do not contract or participate with insurance plans. I hereby authorize Progressive Motion Physical Therapy to furnish my insurance company with any information that may be requested concerning payments of benefits. I understand that I am financially responsible for all charges, whether covered by my insurance or not. I further understand that it is my responsibility to obtain the necessary referrals and/or pre-authorizations from my insurance company.

____**MediCare:** We are not a contracted Medicare provider. As an unfortunate result, federal law prohibits us from treating MediCare Part B recipients, regardless of payment method. Therefore, by signing this document, you are confirming that you are not a current MediCare Part B recipient.

____**Insurance** Billing: Upon request, patients will be provided with a copy of their bill at the end of each visit. They may submit the bill to their insurance company for reimbursement.

____**Medical Record Copies:** Upon written request, patients will be provided a copy of their

medical records.

____Appointments: All patients, students, and class participants must have an appointment. You will receive an e-mail once scheduled, but reminder calls will not be made. If you have missed or cancelled an appointment in less than 24 hours you may be charged for the missed appointment.

____Length of appointments: A portion of your appointment time may be used for billing, payments, discussion of home program, scheduling of future appointments, ordering requested equipment, and/or discussion of treatment goals and procedures with patient/client's physician, parent, coach, or teacher.

____Appointment Cancellations: Progressive Motion Physical Therapy asks that patients provide at least 24 hours notice if you cannot keep your appointment. This must be done via text message, email, or preferably online cancellation of your appointment. If you miss your appointment or give less than 24 hours notice you will be asked to pay prior to future appointments.

____ Late Arrivals: We ask that you arrive on time for your appointment. Unfortunately, if you are late we are not able to give you your full appointment time, as this would inconvenience other patients waiting to be seen. Patients will be charged the fee for the entire scheduled appointment regardless of the time the patient arrives.

___Release of Liability: In consideration of the services provided by Progressive Motion Physical Therapy, I do hereby agree to release personal representative and estate as follows: I understand and acknowledge that the activity I am about to engage in possesses risks which could result in injury. I expressly agree and promise to accept and assume all of the risks existing in this activity. My participation in the activity is purely voluntary, no one is forcing me to participate, and I elect to participate in spite of the risks. I hereby voluntarily release, forever discharge and agree to hold harmless and indemnify Progressive Motion Physical Therapy from any and all liability, claims, demands, actions or rights of action, which are related to, arise out of, or are in any way connected to my participation in this activity.

____ Collaborative Relationship: You have the right to be explained the purpose and benefits of all treatments and exercises. You have a right to terminate treatment at any time. You should communicate any concerns about your treatment

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Direct Physical Therapy Treatment Services You are receiving direct physical therapy treatment services from an individual who is a physical therapist licensed by the Physical Therapy Board of California. Under California law, you may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California, or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice, a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care and that an in-person patient examination and evaluation was conducted by the physician and surgeon or podiatrist.

Patient/Client Signature_____Date_____
Parent Signature (if under 18)_____Date_____
Print Parent Name _____
By signing here, you have legal rights to make medical decisions for this child.

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