FOLSOM PHYSICAL THERAPY
and Training Center
Since 1983

PATIENT CURRENT HISTORY

Describe the current problem that brought you here:

_____

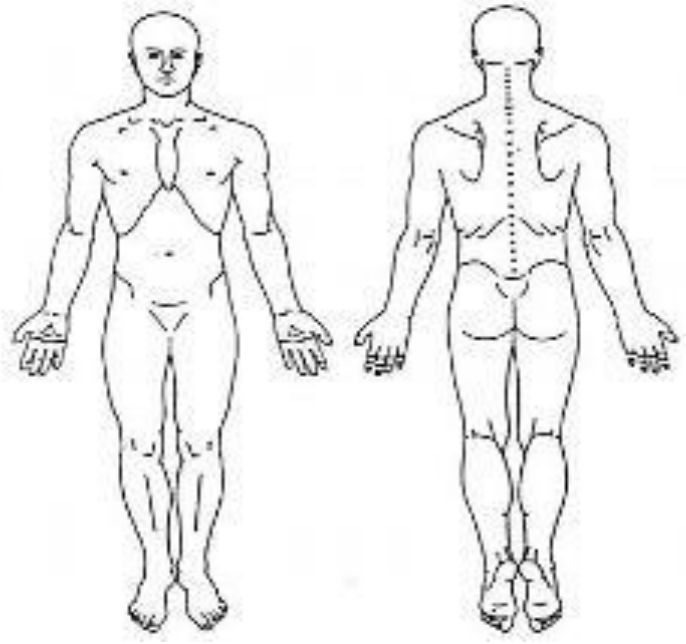
_____

When did your problem first begin? _____weeks ago, or _____months ago, or _____years ago

Since that time is it: staying the _____same _____ getting worse _____ getting better

Why or how might the problem have occurred?

_____



Circle where your symptoms are located and nature of the symptoms (i.e. dull, sharp, tingling, burning, numbness, weakness):_____

_____

On a scale of 0-10, what are your symptoms today? ____/10 When they are at their worst? ____/10

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Activities that cause or aggravate your symptoms: Check or circle all that apply.

_____ Sitting greater than _____minutes
_____ Walking greater than _____minutes
_____ Standing greater than _____minutes
_____ Changing positions (ie.- sit to stand)
_____ Lying on your side
_____ Stairs (going up or down)
_____ Lifting weight overhead
_____ Moving arm overhead/ out to side
_____ Light activity (light housework)
_____ With cough/ sneeze/ straining
_____ With laughing/ yelling
_____ With lifting/ bending
_____ With nervousness/ anxiety
_____ Lying on your stomach or back
_____ Running in straight line, jumping or pivoting
_____ Pushing/pulling on an object
_____ Moving arm behind your back
_____ Vigorous activity/ exercise

_____Other, please list:
_____
_____

Activities that alleviate or lessen your symptoms. Check or circle all that apply

_____ Lying on your back
_____ Sitting upright with support
_____ Reclining
_____ Changing position frequently
_____ Ice
_____ Rest
_____ Lying on your stomach or back
_____ Lying on your back, knees bent
_____ Standing
_____ Exercising
_____ Heat
_____ Walking

____Other, please list:
_____
_____

Describe previous treatments/ exercises (including physical therapy, massage, chiropractic, ect.)
_____
_____
_____

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How has your lifestyle/ quality of life been altered/ changed because of this problem?
Social activities (exclude physical activities), specify_____
_____
Physical activity, specify_____
Work, specify _____

Other _____

What are your treatment goals/ concerns? _____
_____

One month prior to the onset of your current episode, and since that time, have you had:

Y/ N	Fever/ chills	Y/ N	Malaise (unexplained tiredness)
Y/ N	Unexplained weight loss	Y/ N	Unexplained muscle weakness
Y/ N	Dizziness or fainting	Y/ N	Night pain/ sweats
Y/ N	Change in bowel or bladder function	Y/ N	Bilateral numbness/ tingling
Y/ N	Numbness/ tingling to pelvic area	Y/ N	Changes in sexual function

Other please list: _____
_____

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HEALTH HISTORY

Have you, or any immediate family member, ever been told you (they) have:

	Self	Family		Self	Family
Arrhythmias	Y/ N	Y/ N	Asthma	Y/ N	Y/ N
Mitral valve prolapse	Y/ N	Y/ N	COPD	Y/ N	Y/ N
Pacemaker	Y/ N	Y/ N	Chronic bronchitis	Y/ N	Y/ N
Murmur	Y/ N	Y/ N	Congestive heart failure	Y/ N	Y/ N
Heart attack	Y/ N	Y/ N	Episodes of fainting/ blacking out	Y/ N	Y/ N
Angina	Y/ N	Y/ N	Aortic aneurysm	Y/ N	Y/ N
Hypertension	Y/ N	Y/ N	Deep vein thrombosis (DVT)	Y/ N	Y/ N
Hypotension	Y/ N	Y/ N	Raynaud's disease/ phenomenon	Y/ N	Y/ N

If yes to self-history, please list date of onset or if problem is ongoing

_____

_____

_____

Have you, or any immediate family member, ever been told you, or (they) have:

	Self	Family		Self	Family
Stroke	Y/ N	Y/ N	Migraines	Y/ N	Y/ N
Multiple Sclerosis	Y/ N	Y/ N	Unusual or frequent headaches	Y/ N	Y/ N
Polio	Y/ N	Y/ N	Bell's Palsy	Y/ N	Y/ N
Aneurysm	Y/ N	Y/ N	Shingles	Y/ N	Y/ N
Peripheral neuropathy	Y/ N	Y/ N	Seizures	Y/ N	Y/ N
Concussion	Y/ N	Y/ N	Parkinson's Disease	Y/ N	Y/ N
Head trauma	Y/ N	Y/ N			

If yes to self-history, please list date of onset or if problem is ongoing

_____

_____

_____

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Have you, or any immediate family member, ever been told you (they) have:

	Self	Family		Self	Family
Liver problems	Y/ N	Y/ N	Stomach ulcers	Y/ N	Y/ N
Ulcerative colitis	Y/ N	Y/ N	Hemorrhoids	Y/ N	Y/ N
Irritable bowel syndrome	Y/ N	Y/ N	Gallstones	Y/ N	Y/ N
Esophageal reflux	Y/ N	Y/ N	Constipation	Y/ N	Y/ N
Anorexia	Y/ N	Y/ N	Bulimia	Y/ N	Y/ N

If yes to self-history, please list date of onset or if problem is ongoing

_____

_____

_____

Have you, or any immediate family member, ever been told you (they) have:

	Self	Family		Self	Family
Diabetes	Y/ N	Y/ N	Addison's Disease	Y/ N	Y/ N
Hypothyroidism	Y/ N	Y/ N	Cushing's Syndrome	Y/ N	Y/ N
Hyperthyroidism	Y/ N	Y/ N			

If yes to self-history, please list date of onset or if problem is ongoing

_____

_____

_____

Have you, or any immediate family member, ever been told you (they) have:

	Self	Family		Self	Family
Sexually transmitted disease	Y/ N	Y/ N	Urinary incontinence	Y/ N	Y/ N
Sexual dysfunction	Y/ N	Y/ N	Pelvic pain	Y/ N	Y/ N
Sexual abuse	Y/ N	Y/ N	Hysterectomy	Y/ N	

If yes to self-history, please list date of onset or if problem is ongoing

_____

_____

_____

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Have you, or any immediate family member, ever been told you (they) have:

	Self	Family		Self	Family
Osteoporosis	Y/ N	Y/ N	Hip dysplasia	Y/ N	Y/ N
Osteopenia	Y/ N	Y/ N	Scoliosis	Y/ N	Y/ N
Fibromyalgia	Y/ N	Y/ N	Flat feet	Y/ N	Y/ N
Hernia	Y/ N	Y/ N	High arches	Y/ N	Y/ N
Rheumatoid Arthritis	Y/ N	Y/ N	Osteoarthritis	Y/ N	Y/ N
Fractures	Y/ N	Y/ N	Ankylosing Spondylitis	Y/ N	Y/ N

If yes to self-history, please list date of onset or if problem is ongoing

_____

_____

_____

Have you, or any immediate family member, ever been told you (they) have:

	Self	Family		Self	Family
Physical abuse	Y/ N	Y/ N	Anxiety	Y/ N	Y/ N
Verbal abuse	Y/ N	Y/ N	Bi-polar disorder	Y/ N	Y/ N
Depression	Y/ N	Y/ N			

If yes to self-history, please list date of onset or if problem is ongoing

_____

_____

_____

PRESCRIPTION MEDICATIONS (Please list, or attach a copy, of current medications)

Dose	Date or Year Started	Reason for Medication

Over the Counter Medications, Vitamins, or Supplements (Please list, or attach a copy, of current medications)

Dose	Date or Year Started	Reason for Medication

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Please List All Surgeries/ Overnight Hospitalization and Reason Why

Date and type of surgery	Reason

GENERAL HEALTH

Do you smoke? **Y N** If yes, how many cigarettes or packs per day _____/day
Do you use chewing tobacco? **Y N**
Do you drink an alcoholic beverage? **Y N** If yes, how many glasses _____/day or _____/ week
How would you describe your general health? **Excellent Good Average Fair Poor**
What is your current level of stress? **High Moderate Low**
Are you currently seeing a psychologist? **Yes No**
What is your occupation? _____
Do you engage in regular exercise? **None 1-2x/week 3-4x/week 5-7x/week**

If yes, what type of exercise? _____

Please rate your diet: **Poor Fair Moderate Good Excellent**

Typical

Breakfast _____

Lunch _____

Dinner_____

Fluid Intake _____

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CONSENT TO TREAT

Please circle Yes or No:

Were you injured on the job?	Yes	No
Have you filed a work comp. claim?	Yes	No
Were you involved in a Motor Vehicle Accident?	Yes	No
Is this injury involved in litigation?	Yes	No

*We DO NOT accept liens against pending legal settlements.

If you have an Attorney, please fill out the following:
Name of Attorney: _____
Phone: _____ Fax: _____
Address (include city, state & zip): _____

Have you had any Physical Therapy this year at another clinic?	Yes	No

If yes, how many visits? _____

Have you had any Chiropractic visits?	Yes	No

If yes, how many visits? _____

Missed Appointments:
Please notify us at least 24 hours in advance if you cannot keep your scheduled appointment in order for us to be able to fill your appointment time. Cancellations or missed appointments without 24 hour notice are subject to a charge equal to the amount of the appointment.

I, _____, have read and understand that I remain responsible for the total amount due to Folsom
(PRINT NAME HERE)
Physical Therapy for their services and policies, such as that listed above. I, the undersigned, do hereby agree and give my consent to Folsom Physical Therapy to furnish my medical care and treatment considered necessary and proper in assessing or treating my physical condition.

I hereby assign all medical benefits to Folsom Physical Therapy and authorize release of all information necessary to secure payment. A photocopy should be considered valid.

(Patient/Guardian)Signature_____ Date: _____

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FINANCIAL POLICY

Payment is due at the time of service unless special payment arrangements have been approved in advance by our staff. We accept cash, checks, major credit cards (Visa, MasterCard, etc.) We will be happy to process to your insurance claim for reimbursement. However, **it is the patient's responsibility to familiarize themselves with their own insurance policy and understand their terms and coverage thoroughly regarding physical therapy.**

The exact cost of our treatment is impossible to predict as the amount billed varies depending on services rendered at each visit. Reimbursements by insurance companies also vary and are predictably less than the billed amount.

In an attempt to help you understand your financial relationship with us, an estimate of the average cost of treatment is as follows:

	Average Billed Amount	Cash Pay Discount
Evaluation	$225.00	$150.00
Regular follow-up	$125.00	$85.00
Extended Follow-up	$200.00	$150.00

The cash pay discount can be applied if arrangements are made **prior** to initiating treatment and paid at the time service is rendered.

Please do not ask us to retroactively alter our business arrangement with you. Once your insurance has been billed it is very difficult to alter the process.

If you have a large deductible it may be in your best interest to have a cash pay arrangement with us. You may also be capable of submitting your receipts to your insurance company for full or partial reimbursement, or the amount paid applied to your deductible. Your ability to do so and the amount recognized by your insurance company will be dependent of your contract with them.

If you have any questions regarding the above information, please do not hesitate to ask us.

I, _____, have read and understand the Financial Policy as stated above.
(PRINT NAME HERE)

(Patient/Guardian)Signature_____ Date: _____

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PRIVACY PRACTICE

- This notice describes how medical information about you, the patient, may be used and disclosed. It also explains how you can get access to this information. **Please review it carefully**.

Our commitment here at ***Folsom Physical Therapy*** is to serve our patients with professionalism and care, while protecting the privacy and security of all Protected Health Information at all times.

During the course of serving your interests, it may be necessary to share information with other health care providers or business associates. Examples of such instances are described below:

- We may request from your physician MRI's, X-Rays, operation reports and other information that would be helpful in the course of your treatment.
- We use the services of an independent billing company, and so medical information will be passed along to them for billing and payment purposes.

We, here at ***Folsom Physical Therapy***, are committed to obeying all federal, state and local laws regarding privacy practices. If any other uses or disclosures other than those listed above are needed, information will only be released with the written authorization of the individual in question. The individual, as provided by law, may revoke this written authorization at any time.

If you have any questions or comments regarding your protected health information, please contact our offic**e** at **(916) 355-8500**.

I, _____, have read and understand the above Notice of Privacy Practices.
(PRINT NAME HERE)

(Patient/Guardian) Signature: _____Date: _____

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MEDICAL RELEASE AUTHORIZATION

To Whom It May Concern:

I, _____, hereby give my consent for Folsom Physical Therapy to release my Protected
(PRINT NAME HERE)
Health Information (PHI) including physical therapy notes, dates of services, and diagnosis codes, to/from the following person(s)/facilities:

_____, M.D. Effective dates: _____ - _____

This authorization may be revoked at any time by delivering a signed Restriction Request Form to our business office at Folsom Physical Therapy.

Sincerely,

(Patient/Guardian)Signature_____ Date: _____

APPOINTMENT REMINDER

I, _____, would like to receive __text/__email reminders regarding my scheduled
(PRINT NAME HERE)
appointments at Folsom Physical Therapy. I, the undersigned, give Folsom Physical Therapy permission to send my appointment information to me via text/email. I understand that standard text messaging rates will apply to me. I also understand that I cannot reply to the text/email reminders directly, and that I will need to call Folsom Physical Therapy in order to cancel or reschedule an appointment.

(Patient/Guardian)Signature_____ Date: _____

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