PAST MEDICAL HISTORY FORM

Patient Name: ______________________________ **Today's Date:** __________ **Revised Date:**____________

Date of Injury: ______________________________ **Have you ever had these symptoms before?** **YES /NO**

Cause of Injury: _____________________________ **Have you had a related surgery?** **YES / NO**

Primary Care Physician: ______________________ **Referring Physician** **(if different from PCP):** ________________

Are you currently using Home Health Services? **YES / NO** **Dominant Hand (Circle one):** **Left** **Right**

Estimated Height: ______________________________ **Estimated Weight:** _________________________________

<u>DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?</u>

	Yes	No		Yes	No
Diabetes	Y	N	Allergies to Aspirin	Y	N
Chest Pain/Angina	Y	N	Allergies to Heat	Y	N
High Blood Pressure	Y	N	Poor tolerance to cold	Y	N
Heart Disease	Y	N	Other Allergies	Y	N
Heart Attack	Y	N	Hernia	Y	N
Heart Palpations	Y	N	Seizures	Y	N
Pacemaker	Y	N	Metal Implants	Y	N
Headaches	Y	N	Dizziness/Fainting	Y	N
Kidney Problems	Y	N	Recent Fractures	Y	N
Are you Pregnant?	Y	N	Surgeries	Y	N
Cancer	Y	N	Skin Abnormalities	Y	N
Osteoporosis	Y	N	Sexual Dysfunction	Y	N
Bowel/Bladder Abnormalities	Y	N	Nausea/Vomiting	Y	N
Urine Leakage	Y	N	Ringing in your Ears	Y	N
Asthma/Breathing Difficulties	Y	N	Rheumatoid Arthritis	Y	N
Liver/Gallbladder Problems	Y	N	Special Diet Guidelines	Y	N
Smoking	Y	N	Hypoglycemia	Y	N
Infectious Disease	Y	N	Stroke/CVA	Y	N

Please describe any conditions from above.

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Please list current medications you are taking.

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CONSENT FOR MEDICAL AND ASSUMTION OF RISK:

I have been informed that participation in Physical Therapy (PT): may include exercises for strengthening, condition, flexibility, agility and may involve the use of equipment. Such participation has potential mental/physical risks.

During my treatment at Advanced Physical Therapy I agree to the following:

- My participation in each exercise and activity is strictly voluntary and I may choose to limit my participation in any activity at any time.
- I am personally responsible for my own safety during PT. I will monitor and pace myself in a manner that is safe while still actively engaging in each activity.
- I will advise my Physical Therapist of any changes in my physical or mental health prior to participation in each session. I understand that failure to provide this information may have a negative effect with my treatment.
- My Physical therapist is available to answer any questions that I might have regarding my participation in PT and failure to ask these questions may negatively impact my treatment.
- I will seek further direction for anything that I do not fully understand, or that causes me concern.

I hereby accept the responsibility for any harm, injury, or damage that may result from my participation in PT. I hereby waive, release and agree to hold harmless Advanced Physical Therapy for any claim arising out of any injury to me.

HIPAA CONSENT: Health Insurance Portability and Accountability Act

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice also contains a patient rights section describing your patient rights under law. You have a right to review this notice before signing the consent. The terms of the notice may change, and if this should occur, you may receive a revised copy by contacting the office. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, or health care operations. You have a right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in relation to you on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or heal care operations
- The practice has a Notice of Privacy Practices and the patient has an opportunity to review this notice
- The practice reserves the right to change the notice of privacy practices
- The patient has the right to request restricted use of their information
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- Patient information will be kept confidential except as necessary to provide services or to ensure that all administrative matters relating to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers and health insurance payers as is necessary and appropriate for your care. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

CANCELLATION and LATE ARRIVAL POLICY:

When a patient doesn't show for an appointment as scheduled:

- You suffer because you do not receive the treatment needed to prescribe by your doctor and/or PT.
- The therapist now has a space on their schedule that could have been used for another patient in need.

We require the following to avoid a $30.00 charge: _________ Please initial

- 24 hours' notice in the event of a cancellation.
- Unusual circumstances will be considered on a case by case basis.
- All NO SHOWS will be charged.

This charge WILL NOT be covered by insurance, so it will be billed to you personally.

IF YOU ARRIVE LATE for your scheduled appointment you will be given one of the following options per your therapist:

- You may need to reschedule the appointment or
- If possible a portion of the scheduled work will be completed during the remaining appointment time.

______________________________________	______________________________________
Printed Name of Patient	**Signature of Patient or Guardian**
______________________________________	______________________________________
Reviewed By	**Date**