



**PRORESULTS**  
PHYSICAL THERAPY

**New Patient Information**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

If Patient is a Minor, Parent/Legal Guardian Information is Required:

Full Name (First/Last): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Primary Care Doctor's Name: \_\_\_\_\_

Primary Care Doctor's Phone Number: \_\_\_\_\_

Referring Doctor's Name: \_\_\_\_\_

Referring Doctor's Phone Number: \_\_\_\_\_

Emergency Contact/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

Hobbies: \_\_\_\_\_

How did you hear about us: \_\_\_\_\_



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**Insurance Information**

Primary Insurance: \_\_\_\_\_

Primary Insurance Policy ID Number: \_\_\_\_\_

SSN/Benefits Number: \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_

Secondary Insurance Policy ID Number: \_\_\_\_\_

SSN/Benefits Number: \_\_\_\_\_

**For Medicare Patients Only**

Have you had physical therapy this calendar year?      **Yes**      **No**

How many physical therapy visits this calendar year?      \_\_\_\_\_

Are you currently in home health?      **Yes**      **No**

Are you seeking physical therapy because of a work-related accident (worker's comp)?      **Yes**      **No**

Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Adjuster: \_\_\_\_\_ Adjuster Phone: \_\_\_\_\_

Are you seeking physical therapy through a personal injury case?      **Yes**      **No**

Case Number: \_\_\_\_\_ Attorney Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_



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**Patient Consents**

**Consent for Care and Treatment:** I hereby agree and give my consent to ProResults Physical Therapy Inc to furnish appropriate rehabilitative care and treatment, as considered necessary and in the best interest in order to attend to the physical condition. I understand that the benefits and risks to all interventions will be explained and that the patient holds the final judgment in such matters.

**Notice of Patient Information Practices:** I have read and fully understand ProResults Physical Therapy Inc's Notice of Information Practices.

**Authorization to Release Patient Information:** I hereby authorize ProResults Physical Therapy Inc to release any protected health information (PHI) required in the course of my examination or treatment to the insurance company, or their affiliates, of which I provided the information. I also authorize the release of appointment information left in a voice-mail, answering machine, email or text message and understand the level of privacy risk associated with these forms of communication.

**HIPAA Consents:** In compliance with the HIPAA regulations, I consent to the following individuals receiving verbal information regarding the billing of my account.

Name / Relation / DOB: \_\_\_\_\_

Name/ Relation/ DOB: \_\_\_\_\_

**Authorization to Pay:** I hereby authorize payment directly to ProResults Physical Therapy Inc, billing department, for medical services rendered. I understand that I am financially responsible for the charges not covered by my insurance. In the event of default, I promise to pay collection costs and reasonable fees as may be required to obtain collection of this account.

**Patient Commitment and Missed Appointment Policy:** I have read, initialed, signed and fully understand ProResults Physical Therapy Inc's Patient Commitment and Missed Appointment Policy.

**Workers Compensation:** We are required to inform the carrier of all missed or canceled appointment. It is also required to reschedule all missed appointments.

**Authorization to Communicate Electronically:** I understand authorized personnel from ProResults Physical Therapy may communicate with me regarding scheduling/ appointments, the treatment provided, home exercise programs, and educational content as it relates to my condition. I understand that my protected information will not be communicated electronically. I understand that I have the right to opt out of all future communications at any time using the "unsubscribe" option on any forms/ text/email.



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**Patient Consents Continued**

My signature below certifies that I've read, understand, and fully agree to each statement in this document.

Patient's Full Legal Name Printed: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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**Medical History Form**

Name: \_\_\_\_\_

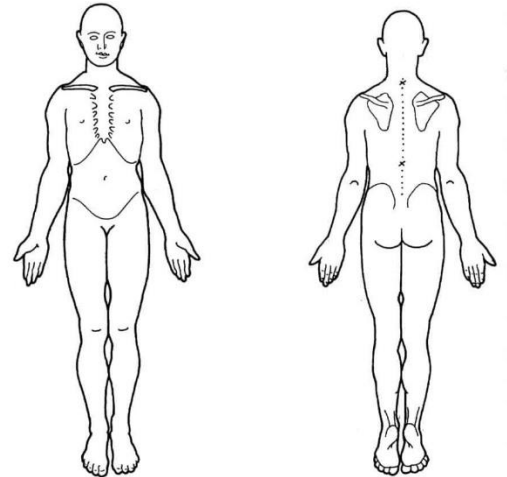
Height: \_\_\_\_\_ ft. \_\_\_\_\_ in.    Weight: \_\_\_\_\_ lbs    Age: \_\_\_\_\_

Area(s) of Injury \_\_\_\_\_

Use the drawing on the right:

- **Shade** in all areas experiencing symptoms (pain, stiffness, aches, etc...)
- **Label** the spot of the worse pain with a small X
- **Circle** any areas of numbness or tingling

1. When did your injury occur? \_\_\_\_ / \_\_\_\_ \_\_\_\_
2. If post-op, when was your surgery? \_\_\_\_ / \_\_\_\_ / \_\_\_\_
3. Pain level:
  - Current pain level \_\_\_\_ / 10
  - Highest pain level \_\_\_\_ / 10
  - Lowest pain level \_\_\_\_ / 10



Medical Questions- (circle yes/no):

1. **Yes / No** Do you have a pacemaker?
2. **Yes / No** Have you experienced significant weight loss recently?
3. **Yes / No** Have you ever had cancer?
4. **Yes / No** Have you had multiple cortisone or predisone injections?
5. **Yes / No** Are you taking any anti-inflammatory medications?
6. **Yes / No** Are you taking any muscle relaxants for this problem?
7. **Yes / No** Are you taking any pain medications for this problem?
8. **Yes / No** Do you have any difficulties with urination?
9. Have you had any of the following for this specific problem:
  - a. **Yes / No**            CT Scan
  - b. **Yes / No**            MRI
  - c. **Yes / No**            X-Ray
10. Is there any condition that you feel may affect your treatment in any way? (*please circle*): heart condition, lung condition, neurological condition, concussion, stroke, osteoporosis, joint replacements, balance deficit, visual impairment, previous surgeries, skin sensitivity, allergies, dizziness, fainting, other: \_\_\_\_\_

*I acknowledge that the above information I have written is true and accurate to the best of my knowledge. I will notify my therapist of any change in condition.*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_