ALAMITOS PHYSICAL THERAPY ASSOCIATES

5122 Katella Avenue, Suite 16 * Los Alamitos, CA 90720
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AlamitosPhysicalTherapy.com * Facebook.com/AlamitosPT

Todays Date:_____

Patient Name:_____ M( ) F( )
Last First MI

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Birthdate:____/____/_____ Age:_____ Drivers License/ID#:_____

SSN:_____ Marital Status:_____ Spouses Name:_____

Employer:_____ Work Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Occupation:_____

Primary Care Physician:_____ Phone:_____

What are we seeing you for?_____

Date of Injury (if applicable):_____ Date of Surgery (if applicable)_____

How were you referred here?_____

Emergency Contact:

Name:_____

Phone:_____ Relationship:_____

PLEASE SUBMIT YOUR INSURANCE CARD(S) AND DRIVERS LICENSE OR ID.

If patient is a minor, name of parent/guardian:_____

Phone:_____ Birthdate:_____ Relationship:_____

Are you on Facebook?_____ Send us a "friend request" or "like us"

Patient History

Federal regulations require a medical history must be included in all patient medical records. This will assist us in properly treating you and identifying possible contraindications for treatment.

Name: (first, middle & last) _____ Ht: _____ Wt: _____

Date of Birth: _____ ***Please Circle***: L- Handed, Rt-Handed, or Ambidextrous

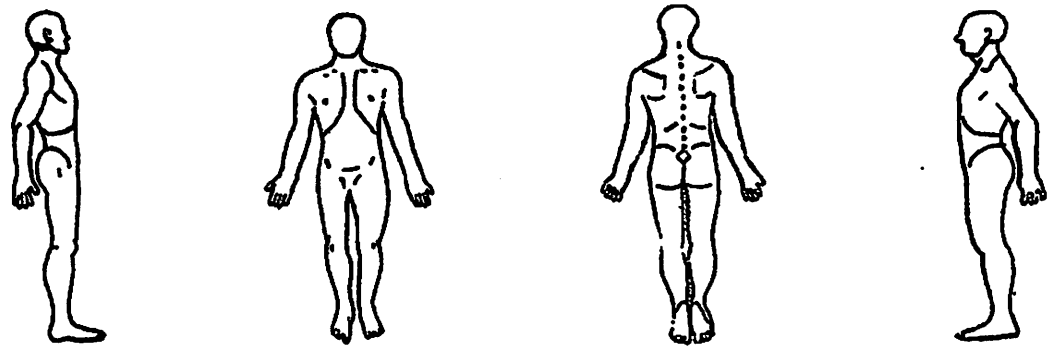
Are you currently receiving Home Physical Therapy/ other Home Care treatments? __Yes __No
Have you received Physical Therapy or Speech Therapy this year? __Yes ___No, If yes, how many? ___ ***If yes to the last 2 questions, please talk with the person at the front desk, before continuing.***
General Health: __ good, __ fair, __ poor; Use of Alcohol __Yes__ No; Use of tobacco __Yes __ No
Chief Complaint? Treatment area? (***Briefly describe injury or how and when complaints began***):_____

_____

_____

_____

Rate your complaint in order of severity (***1= worst, 5 least; circle if applicable and NA if not***)
Pain, Numbness, Tingling: ____
Loss of function: ___ What function(s): _____
Stiffness/Decreased motion: ___ where: _____
Difficulty walking/ Balance problems/Falling: ___; how many falls? __(*due to meds, home hazard, BP, Vision*)
Swelling/edema: ___ Where? _____
Other: _____
Where is your problem? Indicate on body chart: Pain = xxx, Numbness=ooo, Tingling= ###



Describe your **pain and symptoms:** ___ Sharp, ___ Dull ache, ___Piercing, ___ Shooting, ___ Deep, ___ Superficial, ___ Burning, ___ Stabbing, ___ Intermittent, ___ Constant
What makes your symptoms worse?***(please circle)***: walking, standing, sitting, kneeling, bending, squatting, reaching up/behind, up- down stairs, lying down, bowel/bladder function, getting up from sitting or lying down, other?)_____
better? (rest, heat, cold pak, meds, other)_____
Rate your pain (0= no pain, 10= emergency)Now: _____ Initial at time of onset: _____
Worst it has been: _____Past 2-4weeks _____ Last 24hrs _____ Best or least _____

Are your symptoms: Improving_____ Worse _____ Stable _____
Are your symptoms worse in _____morning, _____afternoon, _____, evening,
_____ inconsistent/ no pattern
Do your symptoms wake you up? Yes___ No___ Do you sleep in a ___bed, ___recliner, ___ other
Do you wake up at night? How many times? _____ Why? _____

Did you have surgery for this problem? Type: _____ Date of Surgery: _____
Did you have Physical Therapy previously for the condition? Yes ___ No ___ When? _____
Results: _____

Other surgeries (*list and dates*) – use back side if needed

_____

Hospitalizations (*condition and dates*) - use back side if needed

_____

Has this problem affected your daily life or routine?

_____

Have you had any special tests for this condition (X-Rays, MRI, CT Scan, other)? When and Results? _____
Do you have reports? If yes, please provide: _____
Have you received treatments for this current problem? (***Circle Discipline and results***)
Acupuncture, Doctor's visit (medications, injections, other), Chiropractor, Massage
Other: _____
Results: _____

Please answer the following: (*Please circle and explain below*)	**Yes**	**No**
a. Do your symptoms change with cough or sneeze?	___	___
b. Have you had any changes in bowel or bladder function?	___	___
c. Do you experience any dizziness or vertigo?	___	___
d. Have you had any recent change in your weight or appetite? (Increase/decrease)	___	___
e. Do you have any intolerance to hot or cold?	___	___
f. Do you have any bleeding or bruising disorders? Blood clots?	___	___
g. Have you had any skin changes, such as rashes or discoloration, infections?	___	___
h. Have you experienced any changes in your vision, such as blurring, double vision, or decrease in your visual field? Hearing Impairment?	___	___
i. Have you had had a recent episode of nausea or vomiting?	___	___
j. Do you have Osteoporosis? Osteopenia?	___	___
k. Have you noticed any shortness of breath or decrease in exercise tolerance?	___	___
l. Do you have a history of neck or back problems?	___	___
m. Do you have a loss of sensation? Where?	___	___

_____
_____

Do you have or had any of the following:

1. Diabetes 1 or 2 (circle)	Yes__	No__	17. Autoimmune Diseases	Yes__	No__
2. High Blood Pressure	Yes__	No__	18. Pregnant currently	Yes__	No__
3. Heart Disease/Arrhythmia	Yes__	No__	19. Neuromuscular Disorder	Yes__	No__
4. Heart Attack	Yes__	No__	20. Metal Implants	Yes__	No__
5. Pacemaker	Yes__	No__	21. Cancer	Yes__	No__
6. Congestive Heart Failure	Yes__	No__	22. Loss of consciousness/fainting	Yes__	No__
7. Stroke	Yes__	No__	23. Fibromyalgia	Yes__	No__
8. Kidney Problems	Yes__	No__	24. Hernia (ventral or inguinal)	Yes__	No__
9. Liver Problems	Yes__	No__	25. Tape Allergies	Yes__	No__
10. Breathing Problems	Yes__	No__	30. Latex Allergies	Yes__	No__
11. Digestive Problems	Yes__	No__	31. Other Allergies (meds, foods)	Yes__	No__
12. Peripheral Neuropathy	Yes__	No__	32. Psych. Disorder (ADHD, PTSD)	Yes__	No__
13. Depression	Yes__	No__	33. Anxiety	Yes__	No__
14. Headaches or Migraines	Yes__	No__	34. Seizures	Yes__	No__
15. Cognitive Impairment	Yes__	No__	35. Fracture or suspected	Yes__	No__
16. Unexplained Pain	Yes__	No__	36. Hypo- or Hyperthyroid	Yes__	No__
17. Sleep Apnea	Yes__	No__	37. Sleep Problems	Yes__	No__
18. TMJ Dysfunction	Yes__	No__	38. Other: _____	Yes__	No__

If yes to any of the above, please explain and give approximate dates: _____

_____

_____

Please provide a list of all Over the Counter and Prescription Medications: _____

_____

_____

Please provide list of vitamins, herbs, essential oils, supplements: _____

_____

Presently Working: ___ Yes ___ No, If no, since _____Expect to return to work on: _____

Occupation: _____ General Requirements: _____

Physical Work Demand: ___ Very Light, ___Light, ___ Moderate, ___Heavy, ___Very Heavy

Overall activity level: ___Sedentary, ___Light, ___Moderate, ___Heavy, ___ Very Heavy

Previous exercise/sports/activities (type, frequency, duration):_____

_____

What are your Physical Therapy goals? _____

_____

_____

Do you use any durable medical equipment? (***Please circle***): tub bench, shower chair, raised toilet seat, bedside commode, safety grab bars, standard walker, rolling walker, straight cane, quad cane, wheelchair, crutches; none; other: _____

Anything we missed? _____

I certify that the above information is true and correct to the best of my knowledge

Patient Signature/Guardian: _____ **Date:** _____

Alamitos Physical Therapy

Appointment Cancellation Policy

Dear Valued Patient,

Failure to keep your scheduled appointments at Alamitos Physical Therapy hinders our ability to provide the best care to our patients.

We ask that you show us consideration by calling at least 24 hours prior to your appointment time if you are unable to attend. This will allow us the opportunity to offer that appointment to another patient.

Repeated late cancellations and no-shows are disruptive to the optimal delivery of care to you and our other patients.

Failure to give the 24 hours notice necessary prior to cancellation, will result in a **"No-Show Appointment Fee"**. This fee cannot be billed to your insurance company and will be your direct responsibility.

The No-Show Appointment Fee is as follows:
1st late cancel - $10.00
2nd late cancel - $20.00
3rd late cancel - $30.00
Etc.

We understand that there are special and unforeseen situations that will be assessed on a case-by-case basis.

We reserve the right to "discharge" any patient under our care for non-compliance of appointments.

Signature_____ Date_____

Alamitos Physical Therapy

Billing Policy, Release, Authorization and Collections

I authorize Alamitos Physical Therapy to bill my insurance company directly for the covered portion of charges, and I authorize payment of benefits directly to Alamitos Physical Therapy. I authorize Alamitos Physical Therapy to release medical or other information necessary to process this claim. I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, co-insurance or co-payment, and any charges not reimbursed by my insurance carrier. In the event that I receive payments from the insurance company, I will forward the payments to Alamitos Physical Therapy. I understand that some insurance companies require medical or administrative pre-authorization for treatment, or have reimbursement limits on physical therapy treatments. I understand I am responsible for knowing and meeting the requirements of my insurance plan.

In the event I default on my account, my account will be turned over to your collection agency. If payment arrangements are not kept up on a timely basis and my balance becomes more that 120 days old, you will proceed to send my account to your collection agency. I understand that there is a 2%monthly interest charge if my account becomes past due and should my account be referred for collection or legal matters I will be responsible for a one time $30.00 charge.

Name of patient_____ Date_____

Signature of patient/parent/legal guardian_____

Written Acknowledgement of Receipt of Notice of Privacy Practice

I have received the Notice of Privacy Practices and have had an opportunity to review it.

This Notice describes how my protected health information may be used and disclosed, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Name of Patient_____ Date_____

Signature of patient/parent/legal guardian_____

Privacy Practice is available on request. If you do not wish to receive a copy, please initial here. _____

ALAMITOS PHYSICAL THERAPY PHOTO/VIDEO RELEASE FORM

I hereby grant Alamitos Physical Therapy permission to use my likeness in a photograph, video, or other digital media ("photo") in any and all of its publications, including web-based publications, without payment or other consideration.

I understand and agree that all photos will become the property of Alamitos Physical Therapy and will not be returned.

I hereby irrevocably authorize Alamitos Physical Therapy to edit, alter, copy, exhibit, publish, or distribute these photos for any lawful purpose. In addition, I waive any right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photo.

I hereby hold harmless, release , and forever discharge Alamitos Physical Therapy from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I HAVE READ AND UNDERSTAND THE ABOVE PHOTO RELEASE. I AFFIRM THAT I AM AT LEAST 18 YEARS OF AGE, OR, IF I AM UNDER 18 YEARS OF AGE, I HAVE OBTAINED THE REQUIRED CONSENT OF MY PARENTS/GUARDIANS AS EVIDENCED BY THEIR SIGNATURES BELOW. I ACCEPT:

_____
Print Name

_____ _____
Signature Date

If under 18, BOTH PARENTS MUST SIGN.

_____ _____
Individually and as Parent and/ Date
Legal Guardian

_____ _____
Individually and as Parent and/ Date
Legal Guardian