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Medical Intake Form

Please answer the following questions in order for your physical therapist to provide effective and safe treatment options.

Name: _____ Date of Birth: _____
Email: _____ Phone: _____
Occupation: _____
Emergency Contact (Name & Number) _____

Referring Physician: _____
Medical Diagnosis: _____

What brought you to seek physical therapy?
_____
_____
_____
Cause of Injury (If any):
_____
_____
_____

Please check (✓) any of the following you have seen in the past 6 months:
___Massage Therapist ___Physical Therapist ___Chiropractor

If Yes, Please describe reason(s) for being seen and any results:
_____
_____

Please list any past or upcoming surgeries: _____
_____
_____

Please list any imaging for current injury (CT, MRI, X-Ray): _____
_____
_____

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Please check (✓) if you are currently taking any of the following:
___Anti-Inflammatories ___Muscle Relaxers ___Pain Medication

List all Prescription or Non-Prescription Medications including pills, injections, skin patches, vitamins, herbal remedies and Recreational Drugs currently taking: _____
_____
_____

Do you exercise? ___Yes ___No
If yes, explain type and frequency: _____
_____
_____

Please check (✓) if you have EVER been diagnosed as having any of the following conditions?

___ High blood pressure
___ Circulation problems
___ Varicose Veins
___ Blood Clot/Emboli
___ Epilepsy/Seizures
___ Asthma
___ Anemia
___ Gout
___ Stroke/TIA
___ Blood clots
___ Osteoporosis
___ Osteopenia
___ Rheumatoid arthritis
___ Stomach ulcers
___ Chemical dependency
___ Thyroid problems
___ Diabetes
___ Multiple sclerosis
___ Hernia
___ Depression
___ Hepatitis
___ Tuberculosis
___ HIV/AIDS
___ Arthritic Conditions
___ Kidney Disease
___ Cancer
___ Heart problems
___ Allergies
Other:_____

Please comment if any of the above conditions were checked:_____
_____
_____

Please check (✓) if you have experienced any of the following in the **last 3 months**?

___ Weight Loss/Gain
___ Dizzy/Lightheaded
___ Fatigue
___ Unusual Weakness
___ Fever or Chills
___ Numbness or Tingling
___ Tumors
___ Unusual Muscle Swelling
___ Pregnant or Potentially
___ Stress at Home/Work
___ Loss of Bowel/Bladder
___ Seizures
___ Double Vision
___ Loss of Vision
___ Unusual Eye Redness
___ Skin Rash
___ Problems Sleeping
___ Night Sweats
___ Difficulty Breathing
___ Arm/Leg Swelling
___ Urinary Incontinence
___ Hearing Problems
___ Unusual Joint Swelling
___ Easy Bruising
___ Excessive Bleeding
___ Persistent Cough
___ Heart Racing
___ Difficulty Swallowing
___ Heartburn/Indigestion
___ Constipation/Diarrhea
___ Red/Black Stools
___ Problems Urinating

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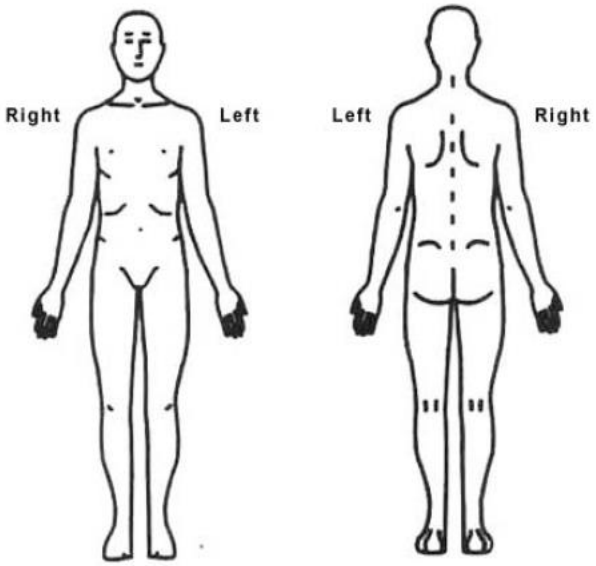
During the past month have felt depressed or hopeless? ___Yes ___ No
During the past month have you been bothered by having little interest or pleasure in doing things?
___Yes ___ No

Please Draw Location of Pain Below



Pain Descriptors:

___ Dull

___ Achy

___ Sharp

___ Constant

___ Shooting

___ Burning

Other: _____

Current Pain Intensity (0 – 10): ____

Pain level at its worst over last 24 hours (0 – 10): ____

Pain level at best over last 24 hours (0 – 10): ____

Any Additional Information/Comments: _____
_____
_____
_____
_____
_____

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Informed Consent for Physical Therapy Services

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Better Build Physical Therapy does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury. It is very important to communicate with you treating physical therapist throughout your treatment.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment. I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

_____	_____	_____
Patient Name	Signature	Date

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Appointment & Payment Agreement Form

To ensure you receive the best possible service, the following information is provided to enhance your understanding of your rights and responsibilities as our patient.

I agree to attend all scheduled appointments, on time. Inform your therapist of your progress, each visit. Comply with your home treatment plan developed by your therapist. Be honest with your therapist about how your home treatment plan is going, as we can only modify it to suit your lifestyle if you're honest with us, and ask questions when you do not understand any instruction.

We request you, our patient, to commit to your care to help us deliver exceptional quality of care. You play a large role in your health by the actions you choose to take day in and day out. Your life is spent the majority of the time outside of our facility, so it is important you understand your responsibilities and commitment as a patient at Build Better. Together, we can undertake the task set before us, as a team. That's the way healthcare is meant to be.

We are making just as much of a commitment to you as you are to yourself. So, help us, help you, on your road of recovery.

I understand that payments are to be collected or settled at the time service(s) are rendered and that I must maintain a valid credit card or have a pre-purchased treatment package online in order to schedule appointments. I understand a scheduled appointment MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE to avoid being charged, and that a no-show or late cancelled appointment will be charged the full amount of the booked appointment. I have read this form in full, and it is my understanding that I am financially responsible for my bills incurred, as well as personally responsible for my care by following through with my recommended home exercise program(s).

_____	_____	_____
Patient Name	Signature	Date

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HIPAA Release Form

Your medical information and identity are protected by the Health Insurance Portability and Accountability Act (HIPAA). HIPPA is a series of standards that disallows a medical patient's information from being shared beyond necessity for medical care. However, in order for us to work together at Ascend and for you to use my website in order to pay and book sessions, some protected health information, such as your name and phone number, must be shared with organizations that will not play a role in your physical therapy.

I, _____, give my permission for Shani Rosenthal to share the information listed in in this document to the person(s) or organization(s) specified in this document.

- Name, birthdate, phone number, home address, and other personal identifying information to **Ascend Summit LLC and related subsidiaries** via signing the gym's waiver.
- Name, birthdate, phone number, home address, billing address, payment details, and other personal identifying information to **Wix.com, Inc**. Though Wix will not share your information or actively use it, Wix services are not designed to be compliant with HIPAA.

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them. I understand that I do not need to give any further permission for the information detailed above to be shared with the person(s) or organization(s) listed above.

_____ _____ _____

Patient Name Signature Date