PATIENT INFORMATION

Patient's Name: ____ **Date:** _______________

Age: _____ **Date of Birth:** ______________ **Sex: Male / Female**

Height: ____**ft.** ____**inches** **Weight:** _________ **Married: Y / N**

Email: ____

Address: ____ **Apt/Suite #:** _________

City: ______________________________ **State:** _______ **Zip Code:** ____________

Cell Phone: ____________________________ **Home Phone:** _____________________________

Emergency Contact: ______________________________ **Phone:** ___________________________

Family Physician: _______________________________ **Phone:** ___________________________

Employer: _____________________________________ **Phone:** ___________________________

Employer Address: ____

Who Referred You: ____

Primary Reason(s) for Seeking Physical Therapy Treatment:

____

Date of Onset of Symptoms/Injury: ____

Are your symptoms due to: Injury at work Y / N Car Accident Y / N Case currently in litigation Y / N

Have you had recent X-ray, CT Scan, MRI, EMG, or other diagnostic tests? Y / N

If yes, please indicate which test(s): ____

(Please provide a copy of any reports if available)

Please check any of following medical professionals you have seen in the last 3 months:

___ Physician (MD, DO) ___ Psychiatrist/Psychologist ___ Chiropractor ___ Dentist

___ Physical Therapist ___ Other: ____________________

What are your goals for rehabilitation?

____

____

Please check if you have recently experienced any of the following:

___ Pain that disturbs your sleep

___ Pain at night or during rest

___ Weight loss >10 pounds for unknown reason

___ Suppressed Immune System

___ Recent infection

___ Bowel or Bladder Dysfunction/Incontinence

___ Fever or chills

___ Blood in stool or urine

MEDICAL HISTORY

Please place a check mark if you have EVER been diagnosed with any of the following:

Cardiovascular/Vascular:

___ Hypertension (High Blood Pressure)
___ Hypercholesterolemia (High Cholesterol)
___ Angina (Chest Pain)
___ Atherosclerosis (Plaque in Arteries)
___ Cerebrovascular Accident (Stroke)
(Please indicate when): ______________________
___ Myocardial Infarction (Heart Attack)
(Please indicate when): ______________________
___ Congenital Heart Disease
___ Bradycardia (Slow Heart Rate)
___ Tachycardia (Fast Heart Rate)
___ Frequent Heartburn
___ Heart Palpitations
___ Known Heart Murmur
___ Cardiac Arrhythmia
___ Blood Clots
___ Varicose Veins
___ Peripheral Vascular Disease (PVD)
___ Circulation Problems
___ Pace Maker or Defibrillator
___ Coronary Angioplasty
___ Cardiac Stent
___ Cardiac Valve Replacement/Repair
___ Other heart/vascular surgery
(Please explain):________________________

Pulmonary:

___ Bronchitis/Emphysema
___ Diagnosed Pulmonary Disease
___ Tuberculosis (TB)
___ Asthma ___ (Exercise Induced Only)
___ Lung Cancer
___ Apnea or Sleep Apnea
___ Dyspnea/Shortness of Breath

Mental/Emotional:

___ Depression
___ Generalized Anxiety
___ Post-Traumatic Stress Disorder
___ ADHD/ADD
___ History of emotional or physical trauma
___ Dyslexia/Learning Disability
___ Memory Loss/Difficulty
___ Substance Abuse/Chemical Dependency
___ Thoughts of harming yourself or another
___ Other (Please list): __________________

Orthopedic:

___ Osteoarthritis (Please indicate where):
____
___ Balance Difficulty
___ Muscle Strain/Sprain (Please indicate where):
____
___ Bursitis
___ Neck Pain
___ Herniated Disc(s) (Please indicate where):
____
___ Lower Back Pain
___ Cervical or Lumbar Stenosis
___ Lordosis
___ Kyphosis
___ Whiplash
___ Vertebral Fracture (Please indicate where):
____
___ Hip Pain/Injury
___ Hip Replacement(s) (R or L)
___ Knee Sprain/Injury (R or L)
___ Knee Replacement(s) (R or L)
___ Ankle Sprain/Injury (R or L)
___ Ankle Edema (Swelling) (R or L)
___ Shoulder Pain/Injury (R or L)
___ Shoulder Tendonitis (R or L)
___ Elbow Pain/Injury (R or L)
___ Wrist/Hand Pain (R or L)
___ Broken Bone(s) (Please indicate where):
____

Other Medical Conditions:

___ Diabetes (Controlled with medication Y/N)
___ Dizziness
___ Hypoglycemia
___ Migraines
___ Headaches
___ Thyroid (Controlled with medication Y/N)
___ Liver problems
___ Gallbladder problems
___ Skin Disorders
___ Multiple Sclerosis
___ Seizures/Epilepsy
___ Anemia
___ Fibromyalgia
___ Vertigo
___ Rheumatoid Arthritis
___ Spondylitis
___ Visual Problems
___ Hearing Loss/Disorder
___ Pulmonary Fibrosis
___ Kidney Disease
___ Gout
___ Raynaud's or Uticaria (Allergy to cold)
___ Past Pregnancy(s) (Cesarian Y/N)
___ Current Pregnancy (____ Months)

Hospitalization/Surgery: (Please list any hospitalizations or surgeries)

Date / Reason for Hospitalization

____
____
____

Date / Reason for Surgery

____
____
____

Family Medical History: (Please check all that apply regarding parents or siblings)

___ Heart Attack ___ Stroke ___ Cancer ___ Diabetes ___ High Blood Pressure
___ Mental Illness ___ Substance Abuse ___ Heart Disease ___ Epilepsy ___Migraines
___ Headaches

Medications: Please include prescription medications, over the counter medication, and supplements

Medication/Supplement	Reason

Allergies: (Please check all that apply)

___ Drug Allergies (Please list): ______________________________________
___ General Allergies (Please list): ______________________________________
___ Latex Allergy/Sensitivity
___ Other Relevant Allergies (Please list): ______________________________________

Have you noticed any of the following: (Please check all that apply)

___ Changes in sleeping habits
___ Changes in mood/emotional expression
___ Changes in eating habits or appetite
___ Feeling of being overwhelmed or anxious
___ Negative feeling about work life
___ Decreased satisfaction with your quality of life
___ Difficulty with memory
___ Regular feelings of sadness or depression
___ Changes in sexual desire
___ Negative feeling about home life

Lifestyle: (Please check all that apply)
___ You are physically inactive
___ You are physically active (Please circle): Low Moderate High
___ You have a history of falling (Please indicate the date of your last fall): ______________________
___ You live alone Do you have assistance at home if needed? Y / N Who: _________________
___ You live/work in a high stress environment
___ You sleep less than 7-8 hours per night Average Hours Per Night:_____
___ You smoke cigarettes Packs Per Day: _____ Years Smoking: _____ Years Since Quitting: _____
___ You drink alcohol Drinks Per Week: __________
___ You drink caffeinated beverages Drinks Per Day: __________
___ Servings of vegetables per day:_____
___ Servings of fruit per day:____

Leisure Activities/Sports/Hobbies:
____

____

Do you work? Y or N What is your position: ____________________________________

If so, how active are you at work? (Please circle) Low Activity Moderate Activity High Activity

Is there any other pertinent information we should be aware of including unlisted signs and/or symptoms of discomfort which you may be experiencing?
____
____
____
____

I, ______________________________, attest that this information is correct to the best of my knowledge.
(Print Name)

Patient/Guardian Signature: ____________________________________ Date: _____________

ACKNOWLEDGEMENT OF PHYSICAL THERAPY TREATMENT LIMITATIONS

According to Pennsylvania/Delaware state law and the Pennsylvania/Delaware State Board of Physical Therapy, a state certified and licensed physical therapist may treat a patient for up to 30 days without a prescription from a physician, physician assistance, nurse practitioner, dentist, or podiatrist. After this 30 day period, I understand that I must be able to provide a prescription for the continuation of physical therapy treatment if it is under the same diagnosis(es) that was originally being treated at the start of the 30 day period.

PRIVACY POLICY

I acknowledge that I have been given an opportunity to review and receive a copy of the Notice of Privacy Practices updated on September 23, 2013. If you would like a copy of the Notice of Privacy Practices, please request one. I understand that Movement Evolved LLC/Aron McConnell, DPT, CSCS will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

CONSENT OF TREATMENT

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while I am a patient/client of Movement Evolved LLC/Aron McConnell, DPT, CSCS. This includes, but is not limited to therapeutic exercise, gait training, neuromuscular re-education, craniosacral therapy, myofascial release, dry needling, electrical stimulation, joint and soft tissue manipulation/mobilization.

BILLING POLICY

Please make sure you call Movement Evolved LLC/Aron McConnell, DPT, CSCS to reschedule your appointment AT LEAST 24 hours before your scheduled appointment if you are not able to make it. You will be charged $50 if you do not provide advanced notice.

Movement Evolved LLC/Aron McConnell, DPT, CSCS is a fee-for-service company. This means that payment is due at the time services are rendered and your insurance company will not be billed. Upon request, receipts can be provided with diagnosis and treatment codes which you may choose submit to your insurance company. If further reports or documentation are requested, these will be provided. *Cash and personal checks are the only forms of accepted payment.*

For Medicare Clients/Patients: Medicare will not pay for services rendered at Movement Evolved LLC/Aron McConnell, DPT, CSCS. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor, healthcare provider, or fitness professional has recommended it. Right now, in your case, Medicare will not pay for services as Movement Evolved LLC/Aron McConnell, DPT, CSCS is not a Participating Provider with Medicare or any other insurance company, and can only agree to work with Medicare clients for fitness, prevention, and wellness goals (which are not covered services under Medicare). You will not be able to submit for reimbursement as the services do not meet the rules set by Medicare regulations. Therefore, any receipts you may request will not include diagnosis codes and other information that Medicare claims usually posses.

Given you will be paying at the time of services, if your insurance company reimburses Movement Evolved LLC/Aron McConnell, DPT, CSCS, these monies will be returned to them and a new check must be cut to you personally.

I ________________________________, by signing this document, acknowledge my consent to the above.
(Print Name)

Patient/Guardian Signature: ____________________________________ Date: _____________

PATIENT-PROVIDER CONTACT AGREEMENT

Federal law now requires very strict limitations on the manner in which providers can contact their patients in order to maintain confidentiality. Although the theory is a good one, it can make life complicated for all of us. I would therefore like to ask you now for permission to contact you in the best way for your lifestyle. Listed below are several options. Please mark the ones you agree to. You may change these at any time by contacting me in writing.

Phone Agreement

Preferred number to use: (please check one) Home ____ Work ____ Cell ____

Home:

____ You may not leave messages on my machine about treatment information, but you may leave appointment reminders.

____ You may leave any kind of message on my machine, including treatment information.

____ You may not leave messages with family members.

____ You may leave messages with family members.

____ I do not have an answering machine.

Work:

____ You may not leave messages concerning treatment information, but you may leave appointment reminders.

____ You may leave messages on my voicemail, including treatment information.

____ You can not contact me at my work.

____ Not applicable to me.

Cell:

____ You may not leave messages on my voicemail concerning treatment information, but you may leave appointment reminders.

____ You may leave any kind of message on my voicemail, including treatment information.

____ I do not have access to voicemail on my cell phone.

Email Agreement

Email is an easy and convenient way for us to communicate. For instance, it allows you to contact me outside of treatment hours. However, please remember that it does have drawbacks. For instance, I may not always have access to my email and when on vacation I may not be able to respond quickly. I will make every effort to check email frequently, but it could be several days before you hear from me. Email is never, ever appropriate for emergencies or urgent questions. It is also not appropriate for any questions that require a good deal of discussion; it is not a substitute for an office visit. Email does not know how to do exams---if you think you need to be seen, please call to make an appointment. Also remember that email is not confidential; my email system has no additional security beyond your usual email provider’s system. You therefore may not want to discuss some sensitive issues via email. Any emails to me become a part of your medical record.

Guidelines for use: Please send your message to asmdpt@gmail.com.

____ I do want to use email to communicate?

____ I do not want to use email to communicate with this office?

Patient/Guardian Signature: ___________________________________ Date: _____________

WAIVER AND RELEASE OF LIABILITY

In agreeing to receive assessment and care provided by Movement Evolved LLC/Aron McConnell, DPT, CSCS at any location I agree to the following:

I fully understand that my medical history is an important factor in the development of my rehabilitation and/or fitness/exercise program. Medicine is not an exact science and no guarantees can be made as to the safety of physical therapy or fitness/exercise activities. I understand that known, unknown, or undisclosed medical or physical conditions may result in injury.

I fully understand and acknowledge that (a) the activities in which I will engage as part of the treatment provided by Movement Evolved LLC/Aron McConnell, DPT, CSCS, the physical therapy and fitness activities, and equipment I may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in my use of any equipment and my participation in these activities; (b) my participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to bodily injury, disease, strains, fractures, partial and/or total paralysis, death or other ailments that, could cause serious disability; (c) these risks and dangers may be caused by the negligence of Movement Evolved LLC/Aron McConnell, DPT, CSCS or the representatives or employees of Movement Evolved LLC/Aron McConnell, DPT, CSCS, the negligence of the participants, the negligence of others, accidents, breaches of contract, or other causes. By my participation in these activities and for use of equipment, I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or the conduct of Movement Evolved LLC/Aron McConnell, DPT, CSCS or the representatives or employees of Movement Evolved LLC/Aron McConnell, DPT, CSCS, or by any other person.

I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Movement Evolved LLC/Aron McConnell, DPT, CSCS and his representatives, employees, and assigns from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for the negligent acts or other conduct by Movement Evolved LLC/Aron McConnell, DPT, CSCS and the representatives or employees of Movement Evolved LLC/Aron McConnell, DPT, CSCS.

I HAVE READ THE ABOVE WAIVER AND RELEASE AND BY SIGNING IT AGREE. IT IS MY INTENTION TO EXEMPT AND RELIEVE MOVEMENT EVOLVED LLC/ARON MCCONELL, DPT, CSCS AND HIS REPRESENTATIVES AND EMPLOYEES FROM LIABILITY FOR PERSONAL INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH CAUSED BY NEGLIGENCE OR ANY OTHER CAUSE.

I ________________________________, by signing this document, acknowledge my consent to the above.
(Print Name)

Patient/Guardian Signature: ____________________________________ Date: _____________