CLIENT INFORMATION

Client Legal Name: _____ **Date:** _____

Preferred Name (if different):_____ **Age:** _____ **Date of Birth:** _____

Sex: Male/Female/Other:_____ **Pronouns: He/Him, She/Her, They/Them, Other:**_____

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

___ Weight loss >10 pounds for unknown reason

___ Recent infection

___ Fever or chills

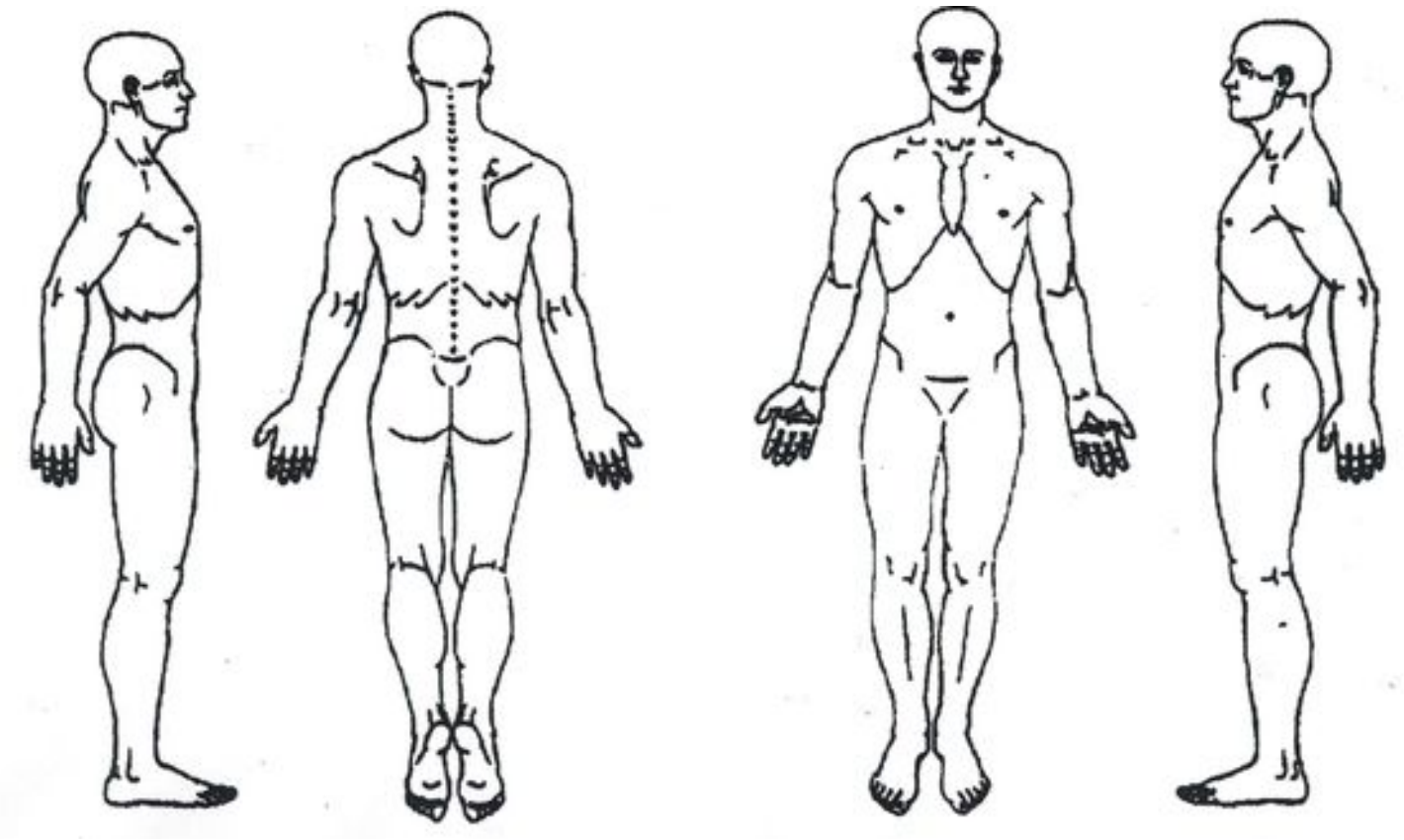
___ Pain at night or during rest

___ Suppressed Immune System

___ Bowel or Bladder Dysfunction/Incontinence

___ Blood in stool or urine

Please indicate on the image below where you experience your symptoms.



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 (CPAP Y/N)
___ Dyspnea/Shortness of Breath

Mental/Emotional:

___ Depression
___ Anxiety
___ Post-Traumatic Stress Disorder (PTSD)
___ 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
___ Scoliosis
___ Sciatica
___ Spondylitis
___ Fracture(s) (Please indicate where):
_____
___ Hip Pain/Injury (R or L)
___ Hip Replacement(s) (R or L)
___ Knee Sprain/Injury (R or L)
___ ACL/PCL Injury (R or L)
___ Meniscus Tear (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)
___ Rotator Cuff Tear (R or L)
___ Elbow Pain/Injury (R or L)
___ Wrist/Hand Pain (R or L)
___ Whiplash
___ Vertebral Fracture (Please indicate where):
_____

Other Medical Conditions:

___ Cancer:_____
___ Diabetes (Controlled with medication Y/N)
___ Dizziness
___ Hypoglycemia
___ Migraines
___ Headaches
___ Thyroid (Controlled with medication Y/N)
___ Liver Dysfunction
___ Gallbladder Dysfunction/Removal
___ Skin Disorders
___ Multiple Sclerosis
___ Seizures/Epilepsy
___ Anemia
___Celiac Disease/Gluten Sensitivity
___Other:_____
___ Complicated pregnancy or delivery
___ Fibromyalgia
___ Vertigo
___ Rheumatoid Arthritis
___ Insomnia/Sleep Disturbances
___ Visual Dysfunction
___ Hearing Loss/Disorder
___ Pulmonary Fibrosis
___ Kidney Disease
___ Gout
___ Raynaud's or Uticaria (Allergy to cold)
___ Past Pregnancy(s) (Cesarian Y/N)
___ Current Pregnancy (____ Months)
___Irritable Bowel Syndrome/Disorder (IBS/IBD)

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
___ Substance Abuse ___ Heart Disease ___ Epilepsy ___Migraines/Headaches
___ Mental Illness/Trauma

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)

___ Activity/Exercise
- ___ You are physically inactive
- ___ You are physically active (Please circle): Low Moderate High
- ___ How often per week do you participate in cardiorespiratory exercise (days): _____
- ___ How often per week do you participate in strength training/resistance training (days): _____

___ 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 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:____
___ Sleep
- ___ You sleep less than 8 hours per night
- ___ Average number of hours slept per night ____
- ___ Rate your average quality of sleep 0-10 ____

___ Stress
- ___ You work is a high stress environment
- ___ Your home is a high stress environment
- ___ How do you reduce stress:_____

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)

Client/Guardian Signature: _____ Date: _____

PRESCRIPTION REQUIREMENT

I, _____, acknowledge that a prescription for physical therapy is required 30 days after the initial evaluation and that it is my responsibility as the client/guardian to obtain this prescription from the appropriate medical professional (physician, physicians assistant, nurse practitioner, chiropractor).

Client/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 client 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, PT, DPT 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 client care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while I am a client/client of Movement Evolved LLC/Aron McConnell, PT, DPT. 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, PT, DPT to reschedule your appointment AT LEAST 24 hours before your scheduled appointment if you are not able to make it. You will be charged $60 if you do not provide advanced notice.

Movement Evolved LLC/Aron McConnell, PT, DPT 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, check, and Venmo are the only forms of accepted payment.*

For Medicare Clients/Clients: Medicare will not pay for services rendered at/by Movement Evolved LLC/Aron McConnell, PT, DPT. 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. Medicare will not pay for services at/by Movement Evolved LLC/Aron McConnell, PT, DPT 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 require for submission, and Medicare will not be billed for these services.

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

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

Client/Guardian Signature: _____ Date: _____

CLIENT-PROVIDER CONTACT AGREEMENT

Federal law now requires very strict limitations on the manner in which providers can contact their clients 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 to which you agree. 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 MovementEvolvedLLC@gmail.com.

____ I do want to use email to communicate?

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

Client/Guardian Signature: _____ Date: _____

WAIVER AND RELEASE OF LIABILITY

In agreeing to receive assessment and care provided by Movement Evolved LLC/Aron McConnell, PT, DPT 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, PT, DPT, 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, PT, DPT or the representatives or employees of Movement Evolved LLC/Aron McConnell, PT, DPT, 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, PT, DPT or the representatives or employees of Movement Evolved LLC/Aron McConnell, PT, DPT, 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, PT, DPT 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, PT, DPT and the representatives or employees of Movement Evolved LLC/Aron McConnell, PT, DPT.

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 McConnell, PT, DPT 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)

Client/Guardian Signature: _____ Date: _____