Patient Information Sheet

Name: ____

Mailing Address: ____

City: ______________________ State: __________ Zip Code: ______________

Home Phone #: __________________ Work Phone #: ______________________

Employer: ____

Address: ______________________ City: ___________ State: ____ Zip: _______

Date of Birth: ________________ Age: _________ Sex: M F

How did you hear about us? _________ Referring Physician: ___________________

Injured at Work? Y N Automobile Accident? Y N

If yes to either question, have you retained an attorney? ______________________

Approximate date symptoms first appeared? _________________________________

Emergency Contact: ____________________________ Phone: ________________

Primary Insurance Name: ____

Secondary Insurance Name: ____

Authorization and Assignment of Benefits

I hereby assign all medical benefits to **Advanced Physical Therapy**.
I understand that I am financially responsible for all charges. I acknowledge, in the event my balance exceeds six months from date of service (excluding insurance payments), the balance will accrue interest at 10% annually. I hereby authorize release of all information necessary to secure payment. A photocopy shall be considered valid. In the event that an insurance payment is not made in a timely manner, I authorize **Advanced Physical Therapy** to file a complaint on my behalf with the California Insurance Commissioner.

Signature ______________________________________ Date: _________________

Patient Information Sheet

Do you have/or had any of the following:

Diabetes	( ) Yes ( ) No	Pacemaker	( ) Yes ( ) No
High blood pressure	( ) Yes ( ) No	Heart Disease	( ) Yes ( ) No
Stroke	( ) Yes ( ) No	Heart Attack	( ) Yes ( ) No
Metal implants	( ) Yes ( ) No	Seizures	( ) Yes ( ) No
Allergies to heat/ice	( ) Yes ( ) No	HIV	( ) Yes ( ) No
Osteoporosis	( ) Yes ( ) No	Hepatitis	( ) Yes ( ) No
Osteopenia	( ) Yes ( ) No	Hernia	( ) Yes ( ) No
Recent fever or chills	( ) Yes ( ) No	Currently pregnant	( ) Yes ( ) No
Recent weight loss	( ) Yes ( ) No	Recent infection	( ) Yes ( ) No
Uncontrollable night pain	( ) Yes ( ) No	Headaches	( ) Yes ( ) No
Personal history of cancer	( ) Yes ( ) No	Kidney problems	( ) Yes ( ) No
Tingling around buttock	( ) Yes ( ) No	Smoking	( ) Yes ( ) No

Recent trauma leading to your current symptoms ( ) Yes ( ) No
Any recent changes in your bowel or bladder function ( ) Yes ( ) No
Have you executed an advance directive ( ) Yes ( ) No

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

____
____
____
____
____

Are you presently taking any medications? ________ If yes, please list medications and for what condition?

____
____
____
____
____
____
____

Have you had previous treatment (physical therapy or chiropractic) in the past 12 months?
Yes_________ No___________

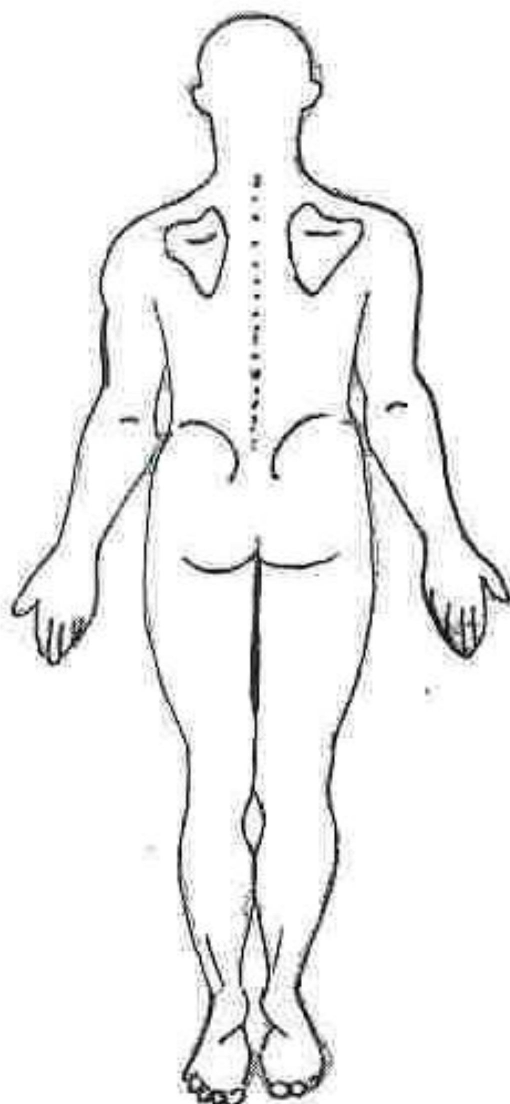
If yes please state
where ____ when _______________________

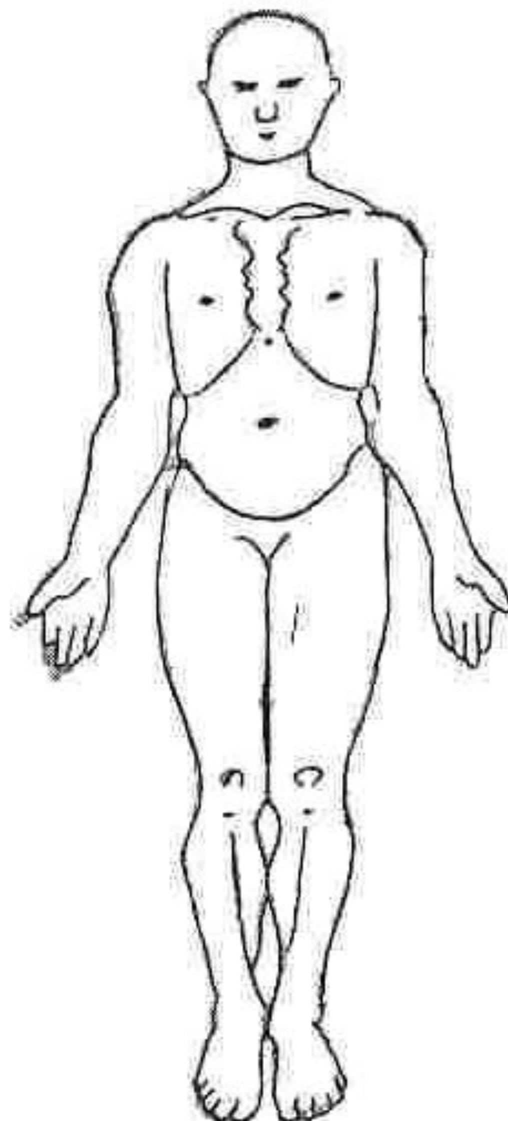
The above information is correct to the best of my knowledge.

Patient Signature:_______________________________________Date:______________

Advanced Physical Therapy • 3084 Cedar Ravine Rd. • Placerville, CA 95667 • Phone: 530-621-2773 • Fax 530-621-3202

ADVANCED
PHYSICAL THERAPY





Please mark on the body where your area(s) of pain/problems are

Patient name: ___________________________________

Patient signature: ______________________________________ Date: __________________

INFORMED CONSENT FOR PHYSICAL THERAPY

Dear Patient:

Physical therapy involves the use of many different types of physical evaluation and treatment. At Advanced Physical Therapy, we use a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition for which you are seeking treatment. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms, and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time before or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

I acknowledge that my treatment program has been explained by Advanced Physical Therapy, and all of my questions have been answered to my satisfaction. I understand the risks associated with a program of Physical Therapy as outlined to me, and I wish to proceed.

______________________________	______________________________	____________
Patient Name	**Patient Signature**	**Date**

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