PHYSICAL THERAPY OF TULSA

Name: _____ _____ Nickname: _____
First Last

Male/ Female Married/Single/Other Date of Birth: _____ SS # _____

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

Email: _____ Home Phone: (____) _____ Cell Phone: (____)_____

Employer: _____ Work Phone: (____) _____

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

How would you like to be reminded about your appointments? ☐ E-Mail ☐ Text Message

If text message please list your cell phone provider: ☐ AT&T ☐ US Cellular ☐ T-Mobile ☐ Verizon ☐ Sprint ☐ Other _____

Emergency Contact Name: _____ Relationship to Patient: _____

Phone number: (_____) _____ Alternate phone number: _____

Responsible Party/Insured Spouse or Parent *(If different from above)*

Name: _____ Relationship to Patient: _____

Phone number: (____) _____ Insured Date of Birth: _____Insured SS#: _____

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

What body part will we be treating? _____

Referring Physician: _____ Is this: ☐Work related ☐Vehicle accident ☐Other accident

Date of Injury and/or surgery: _____Type of injury or surgery: _____

Are there any other insurances involved in your injury/surgery (auto, home, etc)? Yes ☐ No ☐

If yes, please specify :_____

Are you receiving or have you received home health, chiropractic care, or other physical therapy **this year?** Yes ☐ No ☐

I certify that all of the information provided here is true and correct.

_____ _____ _____

Patient/Guardian Signature **Witness Signature** **Date**

PHYSICAL THERAPY OF TULSA

CONSENT TO TREATMENT: I consent to services at Physical Therapy of Tulsa. In so doing, I understand acknowledge and affirm that such services may involve bodily contact, touching, and/or direct contact of a sensitive nature. _____ Initials

TREATMENT OF MINORS: I, as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. _____ Initials

LIABILITY: I know and agree that Physical Therapy of Tulsa is not responsible for lost/damage to personal items. _____ Initials

WAIVER AND RELEASE: I hereby release, discharge and acquit Physical Therapy of Tulsa, its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. _____ Initials

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to Physical Therapy of Tulsa and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the serviced I receive, I will be financially responsible for payment. _____ Initials

CANCELLATIONS/NO SHOWS: We understand that an occasional missed appointment may occur. However, when this happens another patient who could have been seen in your place has their treatment delayed. If you are unable to keep your appointment, we ask that you notify us at least 24 hours in advance so that another patient may be given your appointment time. If you miss your appointment without contacting us by the following business day to confirm your next appointment we will remove all existing appointments until we are contacted. If you are more than 15 minutes late for your scheduled appointment, you will need to reschedule. I understand the Cancellation/No Show policy. _____ Initials

NOTICE OF PRIVACY PRACTICES: I acknowledge receipt of the Notice of Privacy Practices. _____ Initials

I certify that all of the information provided here is true and correct.

_____ _____

Patient/Guardian Signature Witness Signature

PHYSICAL THERAPY OF TULSA

CANCELLATION/NO SHOW AGREEMENT

We understand that an occasional missed appointment may occur. However, when this happens, another patient who could have been seen in your place has their treatment delayed. As a clinic, we at Physical Therapy of Tulsa ask that you agree to the following terms in order for us to provide quality care and optimize communication regarding your scheduled appointments.

If you are unable to keep your appointment, we ask that you notify us at least 24 hours in advance so that another patient may be given your appointment time.

If you miss your appointment without contacting us by the following business day to confirm your next appointment we will remove all existing appointments until we are contracted. If you cancel 3 consecutive appointments, your remaining scheduled appointments will be removed from the schedule until you discuss your plan of care with your therapist.

I, _____, understand and agree to the above CANCELLATION/NO SHOW POLICY.

PRINT NAME

_____

Patient/Guardian Signature

PHYSICAL THERAPY OF TULSA

Name: _____ **Primary Care Physician:** _____

Date of Birth: _____ **Referring Physician:** _____

Have you had physical therapy during this calendar year? ☐ Yes ☐ No

Have you had occupational therapy during this calendar year? ☐ Yes ☐ No

If "Yes," where? _____

Current work status: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Unemployed ☐ Disability ☐ Retired

☐ Other _____ _

Are you pregnant or is there a possibility that you could be pregnant? ☐ Yes ☐ No

What issues are seeking help for from physical therapy/occupational therapy?

_____

_____

Who else have you seen for this issue (check all that apply)? ☐ No one ☐ Medical Doctor ☐ Chiropractor

☐ Physical Therapist ☐ Occupational Therapist ☐ Massage Therapist ☐ Physiatrist ☐ Athletic Trainer

☐ Speech Therapist ☐ Nutritionist ☐ Other: _____

What tests have you had? ☐ X-Ray ☐ CT Scan ☐ MRI ☐ EMG ☐ PET Scan ☐ Ultrasound ☐ Venous Doppler

☐ Angiogram ☐ Other _____

How would you rate your overall health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Do you use tobacco? ☐ Yes ☐ **No** **If "Yes," how much?** _____

What surgeries have you had (Check all that apply)? ☐ Check if you've attached a separate sheet

☐ Cataract ☐ Gallbladder ☐ Prostate ☐ Carpal Tunnel ☐ Tonsillectomy ☐ Hernia ☐ Joint ☐ Heart Bypass

☐ Open Heart ☐ Skin Graft ☐ Back ☐ Neck ☐ Bladder ☐ D & C ☐ Splenectomy ☐ Appendectomy

☐ Hysterectomy ☐ Breast Surgery ☐ Tubal Ligation ☐ C-Section ☐ Colon/Bowel/Intestine ☐ Kidney

☐ Thyroidectomy ☐ Fracture Repair and Location(s) _____

☐ Other: _____

Reviewed:_____

PHYSICAL THERAPY OF TULSA

Name: _____ **Date of Birth:** _____

Past Medical History (Check all that apply): ☐ Check if you've attached a separate sheet

☐ MRSA ☐ Diabetes ☐ Hypertension ☐ Mitral Valve Prolapse ☐ Heart Attack ☐ Congestive Heart Failure

☐ DVT/Clots ☐ Irregular Heartbeat ☐ Pacemaker ☐ Internal Defibrillator ☐ Asthma ☐ COPD

☐ Emphysema ☐ Chronic Bronchitis ☐ Tuberculosis ☐ Frequent Heartburn ☐ Gastric Reflux ☐ Hiatal Hernia

☐ Cirrhosis ☐ Hepatitis ☐ Gallbladder Disease ☐ Stomach Ulcer ☐ Thyroid Disease ☐ Kidney Stone(s)

☐ Kidney Infection ☐ Kidney Dialysis ☐ Anemia ☐ Bruising ☐ HIV/AIDS ☐ Stroke/TIA ☐ Epilepsy/Seizures

☐ Alzheimer's ☐ Parkinson's Disease ☐ Headaches ☐ Restless Leg Syndrome ☐ Fibromyalgia

☐ Spinal Cord Injury ☐ Artificial Joint ☐ Arthritis ☐ Depression ☐ Anxiety ☐ Mental Illness

☐ Metal Implants ☐ Osteoporosis ☐ Osteopenia ☐ Vitamin Deficiency ☐ Other _____

Do you currently have or have you had cancer: ☐ Yes ☐ No (If "No," skip to "Allergies")

What type of cancer? _____

How is it being treated? _____

Allergies (list all):

_____

_____

Current Medications:

☐ Check if you've attached a separate sheet

_____ _____

_____ _____

_____ _____

_____ _____

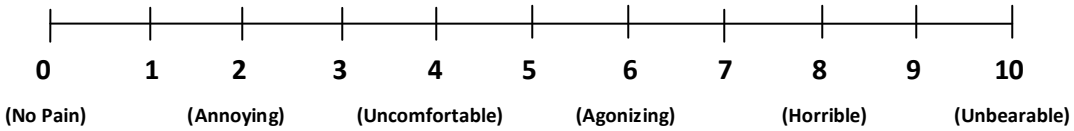
_____ _____

Reviewed:_____

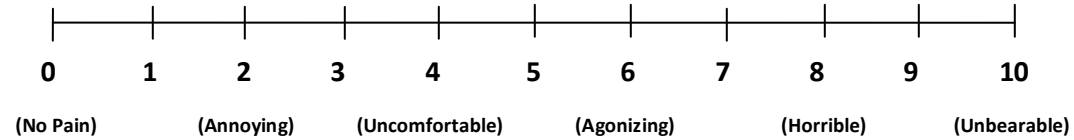
PHYSICAL THERAPY OF TULSA

Name: _____ **Date of Birth:** _____

Please rate your pain today (if applicable):



Please rate your pain at its best (lowest) and at its worst (highest) (if applicable):



Please indicate the location of your symptoms on the diagram. Use the key below to indicate the kind of symptoms you are having.

Sharp: ΛΛΛΛ

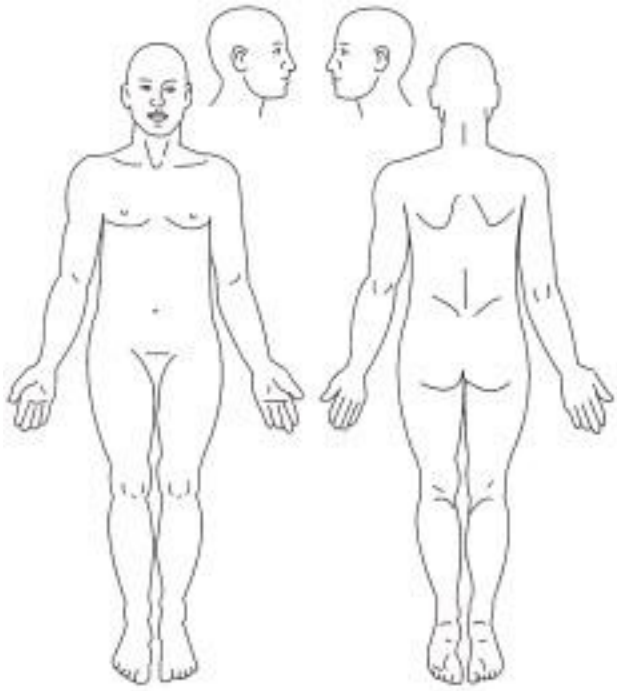
Shooting: ↓↓↓↓

Dull Ache: OOOO

Burning: XXXX

Numbness/Tingling: ////

Other: ++++



Please tell us what things you would like to return to doing that you are having difficulty doing now.

_____

_____

Reviewed:_____

PHYSICAL THERAPY OF TULSA

Name:_____ Date:_____ Date of Birth:_____

At Physical Therapy of Tulsa we appreciate your time and we know you have a lot of paperwork to fill out. We use this information to help us give you the best and most complete care possible. Thank you for answering the following questions to the best of your ability.

Have you recently experienced any of the following:

Abnormal sensations (e.g. numbness, pins and needles)?	Yes	No
Headaches?	Yes	No
Night pain?	Yes	No
Sustained morning stiffness?	Yes	No
Light-headedness?	Yes	No
Trauma (e.g. car accident, fall)?	Yes	No
Night sweats?	Yes	No
Changes in bowel/ bladder (e.g. constipation, frequency, incontinence)?	Yes	No
Easy bruising?	Yes	No
Changes in vision?	Yes	No
Changes in menstruation patterns?	Yes	No
Gait or balance disturbances?	Yes	No
Chest pain with rest?	Yes	No
Shortness of breath?	Yes	No
Muscle weakness?	Yes	No
Failure of conservative intervention (failure to improve within 30 days)?	Yes	No
Excessive sweating?	Yes	No
Edema (swelling) or weight gain?	Yes	No
A heartbeat in your abdomen when you lie down?	Yes	No
Cramps in your legs when you walk for several blocks?	Yes	No
Abdominal pain?	Yes	No
Changes in the integrity of your nails?	Yes	No
Prolonged use of corticosteroids?	Yes	No
Feeling down, depressed, or hopeless?	Yes	No
Being bothered by little interest or pleasure in doing things?	Yes	No

Reviewed _____