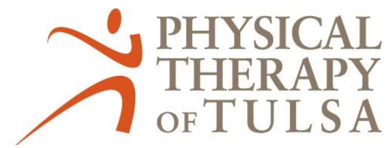


Name: ____________________________ ________________________ Nickname: ______________________
First Last

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.

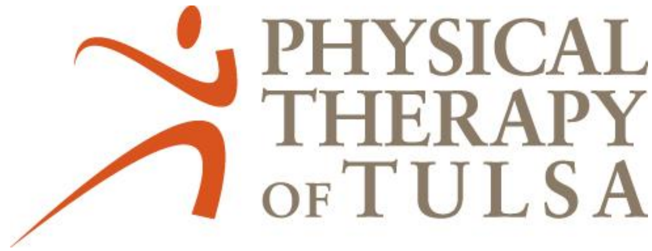
If you miss your appointment without contacting us by the following business day to confirm your next appointment we will remove all existing appointments until we are contracted. If you cancel 3 consecutive appointments, your remaining scheduled appointments will be removed from the schedule until you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

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

PRINT NAME

____

Patient/Guardian Signature



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 __________________________________

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

☐ Angiogram ☐ Urodynamics ☐ Cystoscopy ☐ 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 ☐ Epesiotomy ☐ Colon/Bowel/Intestine

☐ Kidney ☐ Thyroidectomy ☐ Fracture Repair and Location(s)____

☐ All Other Pelvic or Abdominal Surgeries With Date of Operation (When Possible):

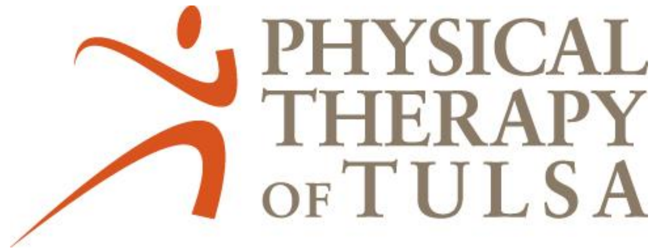
____

____

____

____

Reviewed:_____________________________



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

______________________________________ ______________________________________

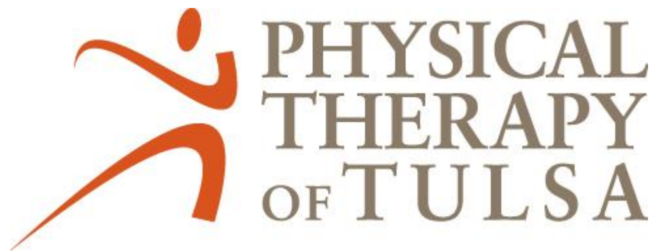
______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

Reviewed:____________________________



Name: ___________________________________ **Date of Birth:** _____________________

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

☐ Nutritionist ☐ 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?

____

When did it begin? ________________ **Is it getting: Better, Worse, or Staying the same (circle one)**

If BOWEL OR BLADDER INCONTINENCE is a problem for you, please answer the following questions, if not please skip to PART B.

PART A

Occurrence of Incontinence or Leakage: ☐ Less than 1x/month ☐ More than 1x/month

☐ Less than 1x/week ☐ More than 1x/week ☐ Almost every day ☐ #___ Leaks per day

Protection Used: ☐ No protection ☐ Pantishield ☐ Mini pad ☐ Maxi pad ☐ Diaper

Severity: ☐ Few drops ☐ Wet underwear ☐ Wet outerwear

Position or Activity with Leakage: ☐ Lying down ☐ Sitting ☐ Standing ☐ Changing positions (sit to stand)

☐ Sexual activity ☐ Strong urge ☐ Coughing, sneezing, bending

Activity that causes leakage: ☐ Vigorous activity ☐ Moderate activity ☐ Light activity

PART B

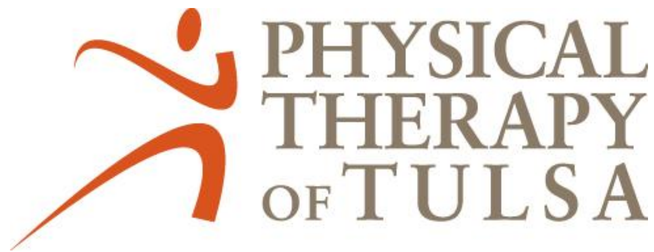
Prolapse (feeling of falling out): ☐Never ☐ Occasionally/With menses ☐ Pressure at the end of the day

☐ Pressure with straining ☐ Pressure with standing ☐ Pressure all day

How long can you delay the need to urinate? ☐ Indefinitely ☐ 1+ Hours ☐ 1/2 Hour ☐ 15 minutes

☐ Less than 10 minutes ☐ 1-2 minutes ☐ Not at all

Reviewed:____________________________



Name: ___________________________________ **Date of Birth:** _____________________

Frequency of Urination (Daytime) ☐ 1-4 times/day ☐ 5-8 times/day ☐ 9-12 times/day ☐ ___times/day

Frequency of Urination (Nighttime) ☐ 0 times/night ☐ 1 time/night ☐ 2 times/night ☐ 3 times/night

Frequency of Bowel Movements ☐ 2 times/day ☐ 1 time/day ☐ Every other day ☐ Once every 4-7 days

After Starting to Urinate, Can You Completely Stop the Urine Flow?

☐ Can stop completely ☐ Can maintain deflection of urine stream

☐ Can partially deflect urine stream ☐ Unable to deflect or slow the urine stream

Do You Have Trouble Initiating Urine Stream?

☐ Never ☐ More than 1 time/month ☐ Less than 1x/month ☐ Daily

Do You Have Pain or Problems With Sexual Activity?

☐ This does not apply to me, as I am not sexually active ☐ No pain with sexual activity

☐ Yes, I have pain with sexual activity

Describe: ____

Do You Have Pain or Problems With Urination?

☐ No pain with urination ☐ Yes, I have pain or problems with urination

Describe: ____

Do You Have Pain or Problems With Bowel Movements?

☐ No pain with bowel movements ☐ Yes, I have pain or problems with bowel movements

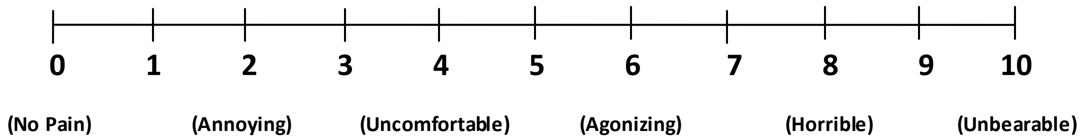
Describe:____

Reviewed:____________________________

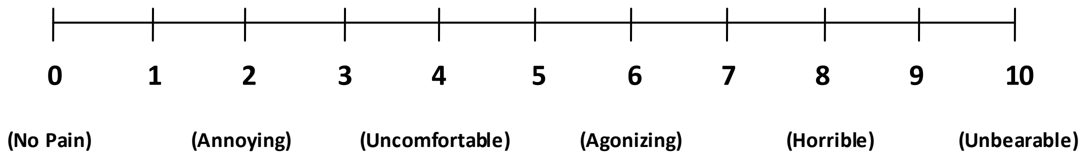
PHYSICAL THERAPY OF TULSA

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: ^^^^

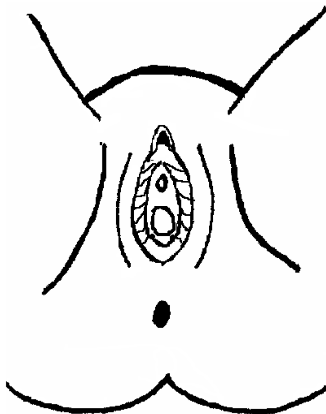
Shooting: ↓↓↓↓

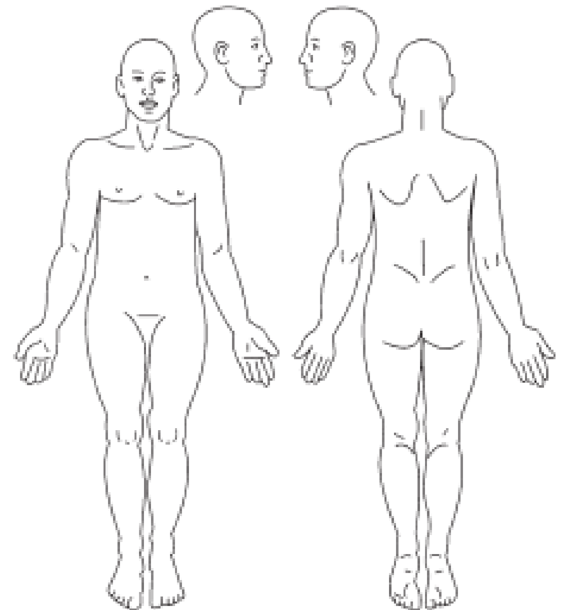
Dull Ache: OOOO

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:___________________________