PRO-ACTIVE
PHYSICAL THERAPY

Colin Broadbelt

1010 Ranch Road 620 South Suite # 106 Lakeway, TX 78734
Cell: 310-387-8838 Fax: (512) 712-5348
www.pro-activept.com | colinbroadbelt@gmail.com

Please take a moment to introduce yourself. All information will remain in your personal file and will be kept strictly confidential.

Personal Information

Title: Mr. Miss. Mrs. Dr.
First Name: _____
Middle Initial: _____
Last Name: _____
Preferred Name: _____
Sex: M F
DOB: ____/____/_____ Age: _____

Address

Street: _____
City: _____
State: _____
Zip: _____
SSN: _____-_____-_____

Contact Information

Home Phone: _____-_____-_____
Work Phone: _____-_____-_____
Cell Phone: _____-_____-_____ Text? ☐
Email: _____
(for appointment reminders)

Responsible Billing Party

Same as above
Name: _____
Street: _____
City: _____
State: _____ Zip: _____

Referral

Who may we thank for your referral?
Dr: _____
Friend: _____
Ad: _____

Emergency Contact Information

Name: _____
Relationship: _____
Phone 1: _____-_____-_____
Phone 2: _____-_____-_____

Marital Status

Single Married Divorced Widowed Engaged
Spouse Name: _____
Spouse Occupation: _____
Spouse Employer: _____

Employment

Employment Status
Employed Unemployed Student
Employer: _____
Occupation: _____
Type of Work: _____

Paying With Credit Card (Visa Or MC)

Credit Card Information ☐Same as Patient
Cardholder Name: _____
Cardholder Address: _____
City: _____
State: _____ Zip:_____
Cardholder Email: _____
Card #: _____ _____ _____ _____
Card Exp Date: _____/_____ (MM/YY)
CVV: _____ (found on back of card)
Charge Card Automatically? ☐ Yes / ☐ No

Patient Signature: _____ Date: _____/_____/_____

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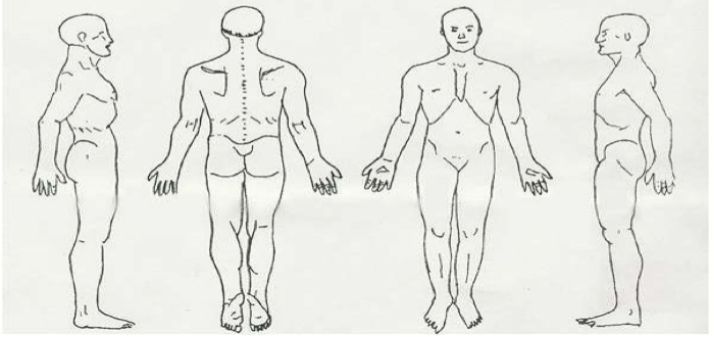
Please mark the figures below in the location of your symptoms.



Have you seen any other physician of medical provider for your current complaint (s)? Yes No

Providers name: _____

Location: _____

What was their diagnosis or impression of your condition?_____

_____

Primary Complaint

Location
- ☐ Neck
- ☐ Mid Back
- ☐ Low Back
- ☐ Shoulder
- ☐ Elbow
- ☐ Wrist
- ☐ Hand
- ☐ Hip
- ☐ Knee
- ☐ Ankle
- ☐ Foot
- ☐ Headache
- ☐ Hamstring
- ☐ Other

_____

Side
- ☐ Left
- ☐ Right
- ☐ Bilateral

Radiating To

Right Left Both
- ☐ Shoulder
- ☐ Arm
- ☐ Buttock
- ☐ Hamstring / Thigh
- ☐ Lower Leg
- ☐ Foot

Type/Onset
- ☐ New Inquiry
- ☐ Reoccurrence or existing problem
- ☐ Chronic Pain
- ☐ Exacerbation of previous injury
- ☐ Unknown Cause
- ☐ Motor Vehicle
- ☐ Accident

Description
- ☐ Achy
- ☐ Stiffness
- ☐ Sharp
- ☐ Dull
- ☐ Shooting
- ☐ Stabbing
- ☐ Burning
- ☐ Numbness
- ☐ Tingling
- ☐ Throbbing

Frequency
- ☐ Occasional
- ☐ Intermittent
- ☐ Frequent
- ☐ Constant
- ☐ With Activity

Progression
- ☐ Getting Better
- ☐ Getting Worse
- ☐ Staying the Same

Aggravate
- ☐ Activity
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Running
- ☐ Bending
- ☐ Getting Up from Sitting
- ☐ Getting Up Lying Down
- ☐ Other

_____

Alleviate
- ☐ Rest
- ☐ Ice
- ☐ Heat
- ☐ Exercise
- ☐ OTC Meds
- ☐ Stretching
- ☐ Nothing

Pain Scale 1-10

Current ___
Average ___
Worst ___

When did your symptoms begin?_____

Briefly describe how your symptoms began: _____

Secondary Complaint

Location
- ☐ Neck
- ☐ Mid Back
- ☐ Low Back
- ☐ Shoulder
- ☐ Elbow
- ☐ Wrist
- ☐ Hand
- ☐ Hip
- ☐ Knee
- ☐ Ankle
- ☐ Foot
- ☐ Headache
- ☐ Hamstring
- ☐ Other

_____

Side
- ☐ Left
- ☐ Right
- ☐ Bilateral

Radiating To

Right Left Both
- ☐ Shoulder
- ☐ Arm
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Health History

Date of Last:
Deny All: ☐

Physical _____
X-ray _____

Spinal _____
MRI/CT _____

Blood Test _____
Urine Test _____

Past or Present Conditions

- ☐ Emphysema
- ☐ Liver Disease
- ☐ Anemia
- ☐ Goiter
- ☐ Ulcers
- ☐ Asthma
- ☐ Chicken Pox
- ☐ Polio
- ☐ Cancer
- ☐ Cataracts
- ☐ Miscarriages
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Osteoporosis
- ☐ Kidney Disease
- ☐ Heart Disease
- ☐ Herniated Disc
- ☐ Rheumatoid Arthritis
- ☐ Chemical Dependency
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Multiple Sclerosis
- ☐ Tumor
- ☐ Appendicitis
- ☐ Breast Lumps
- ☐ Hepatitis
- ☐ Gout
- ☐ Arthritis
- ☐ Suicide Attempts
- ☐ Aids/HIV
- ☐ Epilepsy
- ☐ Tuberculosis
- ☐ Anorexia
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pneumonia
- ☐ Hernia
- ☐ High Cholesterol
- ☐ Migraine Headaches
- ☐ **Deny Any Conditions**

Prescription Medication

- ☐ No Medication
- ☐ Cyclobenzeprene
- ☐ Corticosteroids
- ☐ Birth Control
- ☐ Blood Pressure
- ☐ Skelaxin
- ☐ Gabapintin
- ☐ Thyroid
- ☐ Diuretic
- ☐ Hormone Replacement
- ☐ Flexoril
- ☐ Anti-Inflammatory
- ☐ Anti-coagulant
- ☐ Pain Reliever
- ☐ Cholesterol
- ☐ Medrol Dose Pack
- ☐ Attention Deficit
- ☐ Anti-Seizure
- ☐ Anti-Depressant
- ☐ Allergy/Asthma

Prior Surgeries

- ☐ **No Prior Surgeries**
- ☐ Spinal Injections
- ☐ Shoulder-Right
- ☐ Wrist-Right
- ☐ Hip/Thigh Right
- ☐ Ankle/Leg-Right
- ☐ Breast
- ☐ Brain
- ☐ C-section
- ☐ Cardiovascular
- ☐ Cervical Spine
- ☐ Shoulder-Left
- ☐ Wrist-Left
- ☐ Hip/Thigh-Left
- ☐ Ankle/Leg-Left
- ☐ Tonsil
- ☐ Hernia
- ☐ Other _____
- ☐ Hysterectomy
- ☐ Thoracic Spine
- ☐ Elbow-Right
- ☐ Finger/Hand-Right
- ☐ Knee-Right
- ☐ Foot-Right
- ☐ TMJ-Right
- ☐ Gall Bladder
- ☐ Appendectomy
- ☐ Lumbar Spine
- ☐ Elbow-Left
- ☐ Finger/Hand-Left
- ☐ Knee-Left
- ☐ Foot-Left
- ☐ TMJ-Left
- ☐ Abdominal Organ

Social History

- ☐ No Alcohol
- ☐ Alcohol Drinks 1-2/wk
- ☐ Alcohol Drinks 3-4/wk
- ☐ Alcohol Drinks 5/wk
- ☐ No Caffeine
- ☐ Caffeine <1/day
- ☐ Caffeine 1-3/day
- ☐ Caffeine >3/day
- ☐ No Nicotine
- ☐ Nicotine <3 years
- ☐ Nicotine 3-5 years
- ☐ Nicotine >5 years
- ☐ No Exercise
- ☐ Exercise 1-2 days/wk
- ☐ Exercise 2-4 days/wk
- ☐ Exercise >4 days/wk

Family History (Has any immediate family member been diagnosed with...)

- ☐ Stroke
- ☐ Kidney Disease
- ☐ Alcoholism
- ☐ Other: _____
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Depression
- ☐ I do not know the medical history of my biological family
- ☐ High Blood Pressure
- ☐ Arthritis
- ☐ Asthma
- ☐ Thyroid Disease
- ☐ Osteoporosis
- ☐ Cancer Type: _____

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Recreational Activities

- ☐ Football
- ☐ Volleyball
- ☐ Basketball
- ☐ Baseball/Softball
- ☐ Running ☐ Weightlifting
- ☐ Golf
- ☐ Wrestling
- ☐ Soccer
- ☐ Racquetball
- ☐ Tennis
- ☐ Yoga
- ☐ Biking
- ☐ Track & Field
- ☐ Walking
- ☐ Swimming
- ☐ Rowing/Paddling
- ☐ Hiking/Backpacking
- ☐ Dance/Ballet
- ☐ Martial Arts
- ☐ Horseback Riding
- ☐ Gymnastics
- ☐ Skiing
- ☐ Hockey

General Information

Height _____ Current Weight _____lbs

Do you have a pacemaker or other metal implant? ☐ Yes ☐ No
Females: Is there a chance you could be pregnant? ☐ Yes ☐ No IF Pregnant, how many weeks? ____

Sleeping Position

Primary:	☐ Back	☐ Stomach	☐ Right Side	☐ Left Side
Secondary:	☐ Back	☐ Stomach	☐ Right Side	☐ Left Side
Hand Dominance	☐ Right	☐ Left		
Foot Dominance (foot used to kick a ball)	☐ Right	☐ Left		

Have you recently experienced any...

			Please Explain
Bowel or bladder changes?	☐ Yes	☐ No	_____
Difficultly breathing?	☐ Yes	☐ No	_____
Chest Pains?	☐ Yes	☐ No	_____
Lightheaded or dizziness?	☐ Yes	☐ No	_____
Headaches?	☐ Yes	☐ No	_____
Fevers?	☐ Yes	☐ No	_____
Night sweats?	☐ Yes	☐ No	_____

Health Goals

- ☐ Symptom Relief
- ☐ Increase Flexibility
- ☐ Injury Prevention
- ☐ Improve Quality of Life
- ☐ Increase Athletic Performance
- ☐ Increase Mobility
- ☐ Weight Loss
- ☐ Other _____

Primary Physician

Who is your current primary physician? _____
Where does he/she practice? _____
Would you like our treatment notes sent to them? ☐ Yes ☐ No

Personal Trainer

Do you currently work with a personal trainer? ☐ Yes ☐ No
Name: _____ Location: _____

Patient Signature: _____ Date: _____/_____/_____

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Authorizations and Releases

Patient name (print) _____

Consent for Treatment And Legal Assignment of Benefits

I am aware of the nature and purpose of physical therapy care, the possible consequences and risks of physical therapy care, and the risks and consequences of receiving no such care. I acknowledge that no guarantees were made to me concerning results of treatment. Having this knowledge, I knowingly authorize the therapists of **Pro-Active Physical Therapy** to proceed with the treatment of physical therapy care. Also be advised that this office complies with the guidelines set forth in HIPPAA, which respects your right to privacy. If you are unaware of these rights, please ask for the "Notice of Privacy Practices" and we will provide that for you. In addition,

1. I agree to adhere to my treatment plan. By not doing so, I would release **Pro-Active Physical Therapy** from any consequences that could result from my own actions.

2. I certify that I provided my current insurance card and/ or all insurance information. I assign all insurance benefits payable to my treating physician at **Pro-Active Physical Therapy**. **I understand that I am financially responsible for all charges whether or not paid and/or covered by my insurance plan.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize this signature on all insurance submissions.

3. I agree to be personally responsible for my own property (including children).

4. I certify that the statements on these forms are accurate to the best of my knowledge and I have left nothing out.

Patient signature (guardian) _____ Date _____

Authorization To Release Medical Information

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete. I also authorize the release of my medical information to and from other sources, including, health plans, health care providers, and/or sports personnel. I also understand that if the organization or individual(s) that I authorize to receive my personal health information is not a health plan or health care provider, the released information may be re-disclosed and may no longer be protected by federal privacy regulations.

Furthermore, I request and authorize **Pro-Active Physical Therapy** to release and/or receive specified information from treatments at the given facility. Information released may include, but is not limited to: Medical Records, Medical Statements/ Bills, Doctor Soap Notes, X-Rays, X-Ray Reports, Laboratory Reports, Operative Reports, and Pathology Reports.
I understand that I may revoke this authorization at any time by notifying **Pro-Active Physical Therapy** in writing. However, I fully understand that the revocation will not have any effect on any actions taken before the revocation.

Patient signature (guardian) _____ Date _____

Request For Payment Of Benefits To Provider Of Care

I hereby authorize the_____ insurance company/ insurance administrator to pay by check, and for it to be mailed directly to Colin Broadbelt or **Pro-Active Physical Therapy** at 9004 Wildridge Drive Austin, TX 78759. The expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said professional charges. I agree that this office be given power of attorney to endorse/ sign my name on any and all drafts for payment of my bill.

Patient Signature (guardian)_____ Date _____

Parent Consent To Treat A Minor

I hereby authorize **Pro-Active Physical Therapy** therapists to administer treatment as he/ she deems necessary to my child.
Guardian signature _____ Date _____