

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

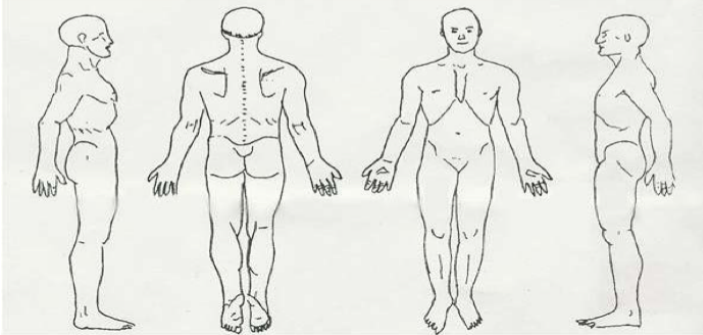
Employment Status
Employed Unemployed Student
Employer: _____
Occupation: _____
Type of Work: _____

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:** ___/___/___

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 | Side | Type/Onset | Description | Frequency | Aggravate | Alleviate | Pain Scale 1-10 |
|------------------------------------|--------------------------------------|--|------------------------------------|---|-------------------------------------|-------------------------------------|-----------------|
| <input type="checkbox"/> Neck | <input type="checkbox"/> Left | <input type="checkbox"/> New Inquiry | <input type="checkbox"/> Achy | <input type="checkbox"/> Occasional | <input type="checkbox"/> Activity | <input type="checkbox"/> Rest | Current ____ |
| <input type="checkbox"/> Mid Back | <input type="checkbox"/> Right | <input type="checkbox"/> Reoccurrence | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Intermittent | <input type="checkbox"/> Sitting | <input type="checkbox"/> Ice | Average ____ |
| <input type="checkbox"/> Low Back | <input type="checkbox"/> Bilateral | or existing problem | <input type="checkbox"/> Sharp | <input type="checkbox"/> Frequent | <input type="checkbox"/> Standing | <input type="checkbox"/> Heat | Worst ____ |
| <input type="checkbox"/> Shoulder | Radiating To | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Dull | <input type="checkbox"/> Constant | <input type="checkbox"/> Walking | <input type="checkbox"/> Exercise | |
| <input type="checkbox"/> Elbow | Right Left Both | <input type="checkbox"/> Exacerbation of | <input type="checkbox"/> Shooting | <input type="checkbox"/> With Activity | <input type="checkbox"/> Running | <input type="checkbox"/> OTC Meds | |
| <input type="checkbox"/> Wrist | <input type="checkbox"/> Shoulder | previous injury | <input type="checkbox"/> Stabbing | Progression | <input type="checkbox"/> Bending | <input type="checkbox"/> Stretching | |
| <input type="checkbox"/> Hand | <input type="checkbox"/> Arm | <input type="checkbox"/> Unknown Cause | <input type="checkbox"/> Burning | <input type="checkbox"/> Getting Better | <input type="checkbox"/> Getting Up | <input type="checkbox"/> Nothing | |
| <input type="checkbox"/> Hip | <input type="checkbox"/> Buttock | <input type="checkbox"/> Motor Vehicle | <input type="checkbox"/> Numbness | <input type="checkbox"/> Getting Worse | from Sitting | | |
| <input type="checkbox"/> Knee | <input type="checkbox"/> Hamstring / | <input type="checkbox"/> Accident | <input type="checkbox"/> Tingling | <input type="checkbox"/> Staying the | <input type="checkbox"/> Getting Up | | |
| <input type="checkbox"/> Ankle | Thigh | | <input type="checkbox"/> Throbbing | Same | Lying Down | | |
| <input type="checkbox"/> Foot | <input type="checkbox"/> Lower Leg | | | | <input type="checkbox"/> Other | | |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Foot | | | | | | |
| <input type="checkbox"/> Hamstring | | | | | | | |
| <input type="checkbox"/> Other | | | | | | | |

When did your symptoms begin? _____
Briefly describe how your symptoms began: _____

Secondary Complaint

| Location | Side | Type/Onset | Description | Frequency | Aggravate | Alleviate | Pain Scale 1-10 |
|------------------------------------|--------------------------------------|--|------------------------------------|---|-------------------------------------|-------------------------------------|-----------------|
| <input type="checkbox"/> Neck | <input type="checkbox"/> Left | <input type="checkbox"/> New Inquiry | <input type="checkbox"/> Achy | <input type="checkbox"/> Occasional | <input type="checkbox"/> Activity | <input type="checkbox"/> Rest | Current ____ |
| <input type="checkbox"/> Mid Back | <input type="checkbox"/> Right | <input type="checkbox"/> Reoccurrence | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Intermittent | <input type="checkbox"/> Sitting | <input type="checkbox"/> Ice | Average ____ |
| <input type="checkbox"/> Low Back | <input type="checkbox"/> Bilateral | or existing problem | <input type="checkbox"/> Sharp | <input type="checkbox"/> Frequent | <input type="checkbox"/> Standing | <input type="checkbox"/> Heat | Worst ____ |
| <input type="checkbox"/> Shoulder | Radiating To | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Dull | <input type="checkbox"/> Constant | <input type="checkbox"/> Walking | <input type="checkbox"/> Exercise | |
| <input type="checkbox"/> Elbow | Right Left Both | <input type="checkbox"/> Exacerbation of | <input type="checkbox"/> Shooting | <input type="checkbox"/> With Activity | <input type="checkbox"/> Running | <input type="checkbox"/> OTC Meds | |
| <input type="checkbox"/> Wrist | <input type="checkbox"/> Shoulder | previous injury | <input type="checkbox"/> Stabbing | Progression | <input type="checkbox"/> Bending | <input type="checkbox"/> Stretching | |
| <input type="checkbox"/> Hand | <input type="checkbox"/> Arm | <input type="checkbox"/> Unknown Cause | <input type="checkbox"/> Burning | <input type="checkbox"/> Getting Better | <input type="checkbox"/> Getting Up | <input type="checkbox"/> Nothing | |
| <input type="checkbox"/> Hip | <input type="checkbox"/> Buttock | <input type="checkbox"/> Motor Vehicle | <input type="checkbox"/> Numbness | <input type="checkbox"/> Getting Worse | from Sitting | | |
| <input type="checkbox"/> Knee | <input type="checkbox"/> Hamstring / | <input type="checkbox"/> Accident | <input type="checkbox"/> Tingling | <input type="checkbox"/> Staying the | <input type="checkbox"/> Getting Up | | |
| <input type="checkbox"/> Ankle | Thigh | | <input type="checkbox"/> Throbbing | Same | Lying Down | | |
| <input type="checkbox"/> Foot | <input type="checkbox"/> Lower Leg | | | | <input type="checkbox"/> Other | | |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Foot | | | | | | |
| <input type="checkbox"/> Hamstring | | | | | | | |
| <input type="checkbox"/> Other | | | | | | | |

When did your symptoms begin? _____
Briefly describe how your symptoms began: _____

Health History

Date of Last: _____ Physical _____ Spinal _____ Blood Test _____
Deny All: X-ray _____ MRI/CT _____ Urine Test _____

Past or Present Conditions

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

Prescription Medication

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> No Medication | <input type="checkbox"/> Skelaxin | <input type="checkbox"/> Flexoril | <input type="checkbox"/> Medrol Dose Pack |
| <input type="checkbox"/> Cyclobenzeprene | <input type="checkbox"/> Gabapentin | <input type="checkbox"/> Anti-Inflammatory | <input type="checkbox"/> Attention Deficit |
| <input type="checkbox"/> Corticosteroids | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Anti-coagulant | <input type="checkbox"/> Anti-Seizure |
| <input type="checkbox"/> Birth Control | <input type="checkbox"/> Diuretic | <input type="checkbox"/> Pain Reliever | <input type="checkbox"/> Anti-Depressant |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Hormone Replacement | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Allergy/Asthma |

Prior Surgeries

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

Social History

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> No Alcohol | <input type="checkbox"/> No Caffeine | <input type="checkbox"/> No Nicotine | <input type="checkbox"/> No Exercise |
| <input type="checkbox"/> Alcohol Drinks 1-2/wk | <input type="checkbox"/> Caffeine <1/day | <input type="checkbox"/> Nicotine <3 years | <input type="checkbox"/> Exercise 1-2 days/wk |
| <input type="checkbox"/> Alcohol Drinks 3-4/wk | <input type="checkbox"/> Caffeine 1-3/day | <input type="checkbox"/> Nicotine 3-5 years | <input type="checkbox"/> Exercise 2-4 days/wk |
| <input type="checkbox"/> Alcohol Drinks 5/wk | <input type="checkbox"/> Caffeine >3/day | <input type="checkbox"/> Nicotine >5 years | <input type="checkbox"/> Exercise >4 days/wk |

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

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Depression | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer Type: _____ |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> I do not know the medical history of my biological family | | |

Recreational Activities

- | | | | |
|---|--------------------------------------|---|---|
| <input type="checkbox"/> Football | <input type="checkbox"/> Golf | <input type="checkbox"/> Biking | <input type="checkbox"/> Dance/Ballet |
| <input type="checkbox"/> Volleyball | <input type="checkbox"/> Wrestling | <input type="checkbox"/> Track & Field | <input type="checkbox"/> Martial Arts |
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Soccer | <input type="checkbox"/> Walking | <input type="checkbox"/> Horseback Riding |
| <input type="checkbox"/> Baseball/Softball | <input type="checkbox"/> Racquetball | <input type="checkbox"/> Swimming | <input type="checkbox"/> Gymnastics |
| <input type="checkbox"/> Running <input type="checkbox"/> Weightlifting | <input type="checkbox"/> Tennis | <input type="checkbox"/> Rowing/Paddling | <input type="checkbox"/> Skiing |
| | <input type="checkbox"/> Yoga | <input type="checkbox"/> Hiking/Backpacking | <input type="checkbox"/> 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 Right Left
(foot used to kick a ball)

Have you recently experienced any...

Please Explain

| | | |
|---------------------------|--|-------|
| Bowel or bladder changes? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Difficulty breathing? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Chest Pains? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Lightheaded or dizziness? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Headaches? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Fevers? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Night sweats? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |

Health Goals

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Symptom Relief | <input type="checkbox"/> Improve Quality of Life | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Increase Flexibility | <input type="checkbox"/> Increase Athletic Performance | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Injury Prevention | <input type="checkbox"/> Increase Mobility | |

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:** ____/____/____

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 HIPAA, 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 _____