



# Thank You for Choosing Concierge Physical Therapy Services

Please print and complete this confidential patient form

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Name: \_\_\_\_\_

Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Gender: \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Who may we thank for referring you to us? \_\_\_\_\_

## Medical History

Have you RECENTLY noted any of the following symptoms? Please check all that apply, and add date and timeframe of symptom(s):

- Cough\_\_\_\_\_ Runny nose\_\_\_\_\_
- Chest tightness\_\_\_\_\_ Difficulty breathing\_\_\_\_\_
- Loss of Smell\_\_\_\_\_ Loss of Taste\_\_\_\_\_
- Numbness or tingling in Arms/Hands\_\_\_\_\_ Legs/Feet\_\_\_\_\_
- Weakness in hands/grip\_\_\_\_\_
- Fever/chills/sweats\_\_\_\_\_
- Diarrhea/Constipation\_\_\_\_\_
- Nausea/vomiting\_\_\_\_\_
- Dizziness/Lightheadedness/fainting\_\_\_\_\_
- Weight loss/gain\_\_\_\_\_
- Heartburn/indigestion\_\_\_\_\_

- Muscle weakness, Fatigue\_\_\_\_\_
- Falls/near falls\_\_\_\_\_ How many in the past 6 months?\_\_\_\_\_
- Difficulty maintaining Balance\_\_\_\_\_
- Do you need a device to walk?\_\_\_\_\_ What do you use?\_\_\_\_\_
- Poor coordination\_\_\_\_\_
- Difficulty Swallowing\_\_\_\_\_
- Ringing or Fullness in ears\_\_\_\_\_
- Changes in bowel or bladder function (urgency, color change, or incontinence) \_\_\_\_\_
- Headaches\_\_\_\_\_ If so, where?\_\_\_\_\_ How long do they last? \_\_\_\_\_
- Vision changes\_\_\_\_\_

Have you ever been diagnosed with any of the following? If so, please write the date of diagnosis and treatment and necessary details

Cancer	Night Sweats
Skin problems	Skin sensitivity
Epilepsy or seizures	Light sensitivity
Stroke	High or low blood pressure
Heart disease, Circulation problems, Blood clots, Vascular disease, Anemia	Chest pain/angina
Lung problem/disease, Pneumonia, Asthma	Diabetes, Neuropathy
Osteoporosis/osteopenia, Bone or joint infection	Osteoarthritis, Other bone or joint condition
Autoimmune Disease	Rheumatoid arthritis
Thyroid problems	Obesity/anorexia
Concussion/Head injury	Headaches, Migraines
Sinus problems	Eye or vision problem
Chemical dependency, alcoholism	Depression, Anxiety, Mental illness
COVID-19	Tuberculosis
Sexually transmitted infection/HIV, Pelvic inflammatory disease	Liver problems/ infection
Kidney problem/infection	Bladder/Urinary tract infection

Parkinson's disease	Multiple sclerosis
Jaw or dental problems	Abdominal pain
High cholesterol	Pregnant/possible pregnancy/breastfeeding

Please disclose any other medical, physical, or mental diagnosis and concerns:

Please list all medications and supplements you are currently taking, including injections and skin patches:

Please list all allergies:

List all prior surgeries, hospitalizations, and fractures, along with date and details (if necessary):

**Lifestyle**

Occupation: \_\_\_\_\_

Activities that compromise your work day: \_\_\_\_\_

Hours of sleep each night: \_\_\_\_\_

Recreational activities and sports: \_\_\_\_\_

Golf \_\_\_ Hockey \_\_\_ Cycling \_\_\_ Running \_\_\_ CrossFit \_\_\_ Tennis \_\_\_ Basketball \_\_\_  
 Mountain biking \_\_\_ Marathon \_\_\_ Martial Arts \_\_\_ Volleyball \_\_\_ Snowboard \_\_\_  
 Hiking \_\_\_ Triathlon \_\_\_ Lifting \_\_\_ Football \_\_\_ Ski \_\_\_ Walking \_\_\_ Swimming \_\_\_  
 Climbing \_\_\_

Other hobbies and activities:  
 \_\_\_\_\_

Do you smoke? Yes \_\_\_ No \_\_\_ If yes, how many packs per day: \_\_\_\_\_

How many alcoholic drinks do you consume per week: \_\_\_\_\_

During the past month have you been feeling down, depressed or hopeless? YES \_\_ NO\_\_

During the past month have you been bothered by having little interest or pleasure in doing things? YES \_\_NO\_\_

Is this something with which you would like help? YES \_\_ YES, BUT NOT TODAY\_\_ NO\_\_

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way?  
YES \_\_ NO\_\_

### Reason for Today's Visit

Please rank the health concerns you would like to address today, and how long have you had symptoms?

1: \_\_\_\_\_

2: \_\_\_\_\_

3: \_\_\_\_\_

Have you been treated by any other health care professional for the above concerns?  
Yes \_\_\_\_ No\_\_\_\_

Name of facility or practitioner: \_\_\_\_\_

Have you ever seen a chiropractor /physical therapist before? Yes\_\_ No\_\_\_  
If yes, when was your last appointment?

Treatment(s) received:

Please list any imaging or special tests performed for this problem (X-Ray, CT scan, MRI, labs, etc.):

Using the 0 to 10 the scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:

Your current level of pain while completing this survey: \_\_\_\_\_

The Best your pain has been during the past 24 hours: \_\_\_\_\_

The Worst your pain has been during the past 24 hours: \_\_\_\_\_

Aggravating Factors: Identify up to 3 important Positions or Activities that make your symptoms worse:

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

How are you currently able to sleep at night due to your symptoms?

- No problem sleeping \_\_\_
- Difficulty falling asleep\_\_\_
- Awakened by pain: and can fall back asleep with repositioning\_\_\_
- Can not fall back asleep with repositioning\_\_\_
- Sleep only with medication\_\_\_

When are your symptoms worse?

Morning\_\_\_ Afternoon\_\_\_ Evening \_\_\_ Night\_\_\_ After exercise or activity\_\_\_

When are your symptoms the best?

Morning\_\_\_ Afternoon\_\_\_\_ Evening\_\_\_ Night\_\_\_ After exercise or activity\_\_

I should not do physical activities that might make my pain worse:

Agree\_\_\_ Disagree\_\_\_ Unsure\_\_\_

What do you think is the cause of your current symptoms?

I certify that I have read and understood the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.

I understand that Concierge Physical Therapy Services is a private payer service. I understand that insurance will not recognize or accept receipts for reimbursement.

I agree to be ultimately responsible for all fees for services rendered and that fees are payable the same date of the services.

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Patients/Guardian Signature Date

**HIPAA Privacy Practices** – Patient Reception Form I authorize the Concierge Physical Therapy Services to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such physical therapy to health care practitioners. I have received or reviewed the privacy practice notice for Concierge Physical Therapy Services, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially initiated care at this office on my first visit, whenever that may have occurred. I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

Patients/Guardian Signature Date \_\_\_\_\_

Print Name: \_\_\_\_\_

I allow Concierge Physical Therapy Services to discuss my treatment and diagnosis with the following doctors, health care professionals, coaches, lawyers, spouses, etc.

Name, Title \_\_\_\_\_

**INFORMED CONSENT TO TREAT**

I request and consent to the performance of chiropractic, physical therapy and massage treatments; including any diagnostic tests performed by Concierge Physical Therapy Services, who now or in the future treat me. I understand and am informed that in the practice of medicine there are some risks to treatment; including, but not limited to: fractures, disc injuries, strokes, dislocations, falls, dizziness, headaches, bruising, sprains, and muscle soreness. I do not expect physical therapists to be able to anticipate and explain all risks and complications. I wish to rely on the healthcare providers to exercise judgment during the treatment based upon the facts then known, in my best interests.

I have read, or had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures.

I consent to allow dry needling services as professionally discussed with the understanding of risk factors involved including soreness, bruising, and rare risk of pneumothorax.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature (Or Patient Representative and title) \_\_\_\_\_

Date \_\_\_\_\_