Thank You for Choosing Concierge Physical Therapy Services

Please print and complete this confidential patient form
E-mail: karencerasoDPT@gmail.com

Name:_____
Date:_____ Date of Birth:_____ _____Age: _____
Address:_____
City: _____ State:_____ Zip:_____
Phone:_____ Gender:

Email Address:_____

Emergency Contact Name:_____ Relationship:_____
Phone Number:_____

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:

Please 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.

_____

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 _____

Concierge Physical Therapy Services requires a 24 hours notice to cancel or reschedule your appointment.

We understand life happens and you may need to miss a scheduled appointment. However, please be considerate and provide adequate notice if you cannot attend. If you late cancel, reschedule late, or no show, we are then unable to give that appointment to someone else who needs our assistance.

Late Cancel or Late Reschedule: If you need to reschedule a session, you are more than welcome to do so, as long as you provide more than 24 hours' notice before your scheduled appointment. If you cancel or reschedule within 24 hours of your appointment, you are responsible for a $70 fee.

No-Show: If you schedule an appointment and do not come to your appointment, you are responsible for the full hour session of $140

Late (or not ready on arrival): You may complete the remaining time scheduled for your session, knowing that you will not receive a full hour session, but are responsible for the full hour fee of $140. As a courtesy, we can go over if we have the time.

We truly do not want to have to charge you for sessions you did not attend. These policies are in place because we've found that they encourage patient commitment and compliance to their rehabilitation goals. We will send you a bill with the date of the missed service in the event you cannot make it. We appreciate your understanding.

By signing below, you acknowledge that you have read, understand, and agree to all the policies listed above.

Patient or Guardian Signature _____Date_____