Date: _____

Proven Physical Therapy

MEDICAL HISTORY FORM

Patient Name:_____Email:_____

Referring Physician:_____Primary Physician:_____

Did you have surgery?_____When? Give Date:_____

What surgery was done?_____

When is your next Doctor's appointment? Give Date:

What body part are you here for?_____

When did your condition start? Give specific date of injury or onset:_____

Have you had previous physical therapy for this condition? _____

Did you have any of the following tests? Height:_____

X-Ray MRI CT EMG Other:_____ Weight:_____

Are you currently experiencing or have you experienced any of the following? Circle all that apply.

	Yes	No		Yes	No
Diabetes			Hernia		
High Blood Pressure			Nervous Disorders/Depression		
Heart Disease			Seizure		
Heart Attack			Allergies/Skin		
Pacemaker			Headaches/Dizziness		
Heart Murmur/Arrhythmia			Metal Implants		
Stroke			Recent Fatigue/Weakness		
Shortness of Breath			Recent Fever		
Asthma			Recent Nausea/Vomiting		
Cancer			Recent Chills/Sweats		
Thyroid Problems			Recent Weight Gain or Loss		
Kidney Problems			Injured in a Motor Vehicle Accident		
Infectious Disease/HIV/Hepatitis			Any Previous Injury		
Pregnant/IUD			Previous Surgery		

If YES on any of the above, please give details and approximate dates:_____

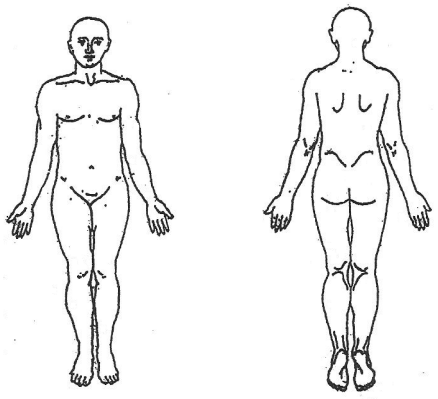
Are you currently taking any MEDICATIONS? Please List: _____

_____

Do you have PAIN? If so, DRAW on the BODY CHART where you pain is located

What does your pain feel like? (Circle all that apply.)

Sharp Burning Aching Tingling Numbness Other:__



Does pain radiate to arms and/or legs?_____

Rate your pain on a 0-10 scale (0=None, 10=Severe)

Does your pain awaken you at night?_____

If so, how many times each night? _____

What makes the pain WORSE?

Lying Down Sitting Standing Walking Other:_

What EASES the pain?

Lying Down Sitting Standing Walking Other:_

Functional Activities: Can you drive?____Can you climb stairs?____Are you able to provide self-care?_____

Leisure Activities: Please List:_____

Is there anything else you want us to know about your condition?_____

PROVEN
PHYSICAL THERAPY

CONSENT AND STATEMENT OF FINANCIAL RESPONSIBILITY

CONSENT FOR TREATMENT: I hereby consent to, and authorize my physical therapist and other health care professionals who may be involved in my care, to provide care and treatment prescribed by my physician and/or considered necessary or advisable by my physician, physical therapist or other healthcare professionals. I understand that my treatment may include techniques that can result in bruising, reddening of the skin, soreness after treatment and hematoma, including, without limitation, myofascial decompression and blood flow restriction. I understand that it is my responsibility to inform my physical therapist or other health care professional if I experience any discomfort or pain during any treatment or if I have other unresolved concerns around my treatment. I understand that response to physical therapy intervention varies from person to person and it is possible that treatment may result in aggravation of existing symptoms or may cause pain or injury.

APPOINTMENT ATTENDANCE AGREEMENT: I understand the importance of attending therapy consistently, scheduling appointments in advance and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand and acknowledge that appointment times given one week may not be available in subsequent weeks. I agree to provide at least a 24 hours' notice when I need to cancel or reschedule an appointment.

RESPONSIBILITY FOR PAYMENT: All co-payments, and self-pay services are due at the time of service. I acknowledge that in consideration of the services provided to me by Proven PT. I am financially responsible for payment of my bill. It is my responsibility to provide Proven PT with my current insurance information, to familiarize myself with my insurance benefits and any questions I have should be directed to my health plan. My health insurance plan may provide that all or a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance. I understand Proven PT will bill my insurance carrier as a courtesy, but that I am ultimately responsible for any amounts owed.

ASSIGNMENT OF BENEFITS: I hereby assign to Proven PT all my rights and claims for reimbursement under my health insurance policy. I agree to cooperate with Proven PT and to provide such information as is needed to establish my eligibility for such benefits.

WORKERS COMPENSATION PATIENTS: I understand that Proven PT is required to inform my Worker's Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments.

ACCESS TO AND RELEASE OF HEALTH INFORMATION: I understand that Proven PT may document medical and other information related to my treatment in electronic or other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment.

By my signature below, I certify I have read, understand and fully agree to each of the statements in this document and sign freely and voluntarily.

_____ _____

Signature of Patient or Legally Responsible Person Date

If you have any questions, please contact: 248-773-7540 / email: info@provenpt.com