MEDICAL HISTORY QUESTIONNAIRE

NAME _____ AGE: _____ DATE: _____

WEIGHT: _____ HEIGHT: _____ MARITAL STATUS: _____ GENDER: _____

WHY ARE YOU HERE TODAY? _____

HOW AND WHEN DID SYMPTOMS/PAIN BEGIN? _____

_____

OTHER TREATMENT (PT, CHIROPRACTIC, ETC): _____

DATE OF LAST PHYSICAL: _____ TESTS (XRAY, MRI, BONE SCAN, ETC): _____

ALLERGIES: _____ ARE YOU ALLERGIC TO LATEX : YES / NO

CURRENT MEDICATIONS: _____

_____

_____

SURGERIES (in the last 5 yrs): _____

Have you or any immediate family member been told you have? Please circle YES or NO.

	SELF	**FAMILY**		**SELF**	**FAMILY**
Cancer	YES / NO	YES / NO	Diabetes	YES / NO	YES / NO
High Blood Pressure	YES / NO	YES / NO	Heart Disease	YES / NO	YES / NO
Angina/Chest Pain	YES / NO	YES / NO	Stroke	YES / NO	YES / NO
Osteoporosis	YES / NO	YES / NO	Tuberculosis	YES / NO	YES / NO
Arthritis	YES / NO	YES / NO	Thyroid condition	YES / NO	YES / NO

Do you have a history of:

Allergies/Asthma	YES / NO	Headaches	YES / NO	Bronchitis	YES / NO
Kidney Disease	YES / NO	Rheumatic fever	YES / NO	Ulcers	YES / NO
Seizures	YES / NO	Hepatitis	YES / NO		

In the past 3 months have you had or do you experience:

A change in your health	YES / NO	Nausea	YES / NO
Fever/chills/sweats	YES / NO	Unexplained weight change	YES / NO
Numbness/tingling	YES / NO	Changes in appetite	YES / NO
Difficulty swallowing	YES / NO	Changes in bowel	YES / NO
Shortness of breath	YES / NO	Changes in bladder function	YES / NO
Dizziness	YES / NO	Upper respiratory infection	YES / NO
Urinary tract infection	YES / NO		

Are you currently:

Pregnant	YES / NO
Depressed	YES / NO
Under stress	YES / NO
Have a pacemaker	YES / NO

How are you sleeping at night? (circle one)

Fine Moderate difficulty Only with medication

Do you or have you smoked tobacco? YES / NO

If yes: # packs/day _____

years _____ Last use: _____

I currently have difficulty with: (check all that apply)

☐Driving ☐Getting up from a chair ☐Walking ☐Bending at the waist

In case of emergency, please contact:

_____#_____

OR _____#_____

Panther
PHYSICAL THERAPY

Date: _____

Patient Name: _____Med Rec # / Account#_____

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND TERMS OF TREATMENT

I hereby consent to the use and disclosure of my health information for treatment provided to me by **Provider**, payment for services provided by the Provider or other health care providers and the operations of the Provider and others under certain circumstances. I understand that a more detailed explanation of the ways the Provider may use and disclose my health information is contained in the Notice of Privacy Practices of the Provider, a copy of which has been provided to me.

Authorization to Release Information

My signature below constitutes my permission for Provider to discuss my protected health information with following individuals:

_____	_____	_____
Name of Authorized Individual	Relationship	Phone#
_____	_____	_____
Name of Authorized Individual	Relationship	Phone#

Referring Physician/Practitioner: _____

□ I authorize Provider to send a 'thank you' acknowledgement to my referring physician/practitioner that identifies me by name.

CONSENT FOR TREATMENT:
Knowing that I have a condition requiring treatment by Provider, I do hereby voluntarily consent to such treatment as deemed necessary in the judgment of Provider.

FINANCIAL RECORDS CONSENT AND INSURANCE ASSIGNMENT OF BENEFITS:
I certify the information given to me in applying for payment under Title XVIII of the Social Security Act or other financial carriers is correct. I assign payment directly to Provider for unpaid charges. I agree to pay Provider for these services and supplies according to its regular rates and charges at the time these services and supplies are rendered. I understand that I am responsible for any health insurance deductibles, co-insurance and any amounts not paid by my insurance carrier. If this account is delinquent, I agree to pay all expenses including, but not limited to collection fees, court costs and actual attorney fees incurred by Provider in collecting this account.

CONSENT FOR DISCLOSURE FOR DURABLE MEDICAL EQUIPMENT:
I consent to allow Provider to release my outpatient treatment records to durable medical equipment suppliers to simplify ordering my durable medical equipment. Specific information disclosed will be a patient information face sheet, physician orders and selected information to process my durable medical equipment order.

Panther
PHYSICAL THERAPY

Med Rec # / Account #: _____

CANCELLATION AND NO SHOW POLICY:
I understand that Provider is committed to providing all of your patients with exceptional care. When a patient cancels without giving enough notice or misses an appointment, that patient prevents Provider from providing care to another patient. A cancellation is considered to be late when the appointment is not cancelled at least 24 hours prior to the scheduled appointment. To encourage timely notification and reduce missed appointments, Provider has adopted the following policy:

First late cancellation or missed appointment: **$0 fee.**
Second late cancellation or missed appointment: **$25.00 fee.**
Third late cancellation or missed appointment: **$25.00 fee** plus, at Provider's discretion, cessation of further care to the patient.

I acknowledge that the foregoing fees are **not** covered by insurance and **must** be paid by me prior to the next scheduled visit.

Planned absences from scheduled therapy will not be considered cancellations or no-shows. If I provide notice of a planned absence, my on-going schedule may be placed on "hold" for up to two (2) weeks. I acknowledge that a renewed prescription and appointment schedule may need to be arranged depending on the length of time which has passed.

TELEPHONE CONSUMER PROTECTION ACT NOTICE:
In order to service your account or to collect any amounts I may owe, you may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in a charge to me. You may also contact me by sending text messages or e-mails, using an e-mail address I provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

My signature below indicates that I understand the terms of treatment by Provider.

Patient's Signature: _____
Date: _____
Print Name: _____ (**when patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required).**

Signature of Legal Representative: _____
Date: _____
Print Name of Legal Representative: _____
Description of Legal Representative Authority: □ Parent □ Medical Power of Attorney (attach documentation)
□ Other _____ (Explain and Attach Documentation)

Panther
PHYSICAL THERAPY

Patient Name: _____ Med Rec # / Account #: _____

Communication Consent Form

In order to effectively communicate with you, we request that you complete this form, identifying the best ways to provide you with your confidential information. We may need to communicate appointment reminders, referral and authorization information and/or respond to a message you left for the office, etc. We might communicate with you through mail, electronically and/or by telephone. This may include leaving messages on your answering machine/voice mail or sending messages via text and email.

Please check all boxes that you give _____ permission to use for your communications:

□ You may contact me by telephone/leave a voice mail Phone Number(s): _____

□ You may contact me by text message Phone Number(s): _____

You may contact me by email with the following types of information: (check all that apply)

□ Appointment Reminders □ Provider Updates / Announcements / Satisfaction Survey □ Clinic Promotions

Email address: _____

Preferred contact method: □ Phone □ Text □ Email

Primary Language: □ English □ Spanish □ Other _____

- E-mail correspondence will be between Provider and an adult Patient 18 years or older, or parent or legal guardian of a minor Patient.
- Patient and Provider will not use email for communicating sensitive medical information. Although Provider has implemented reasonable technical safeguards, there is a potential that Email sent or received over the Internet can be intercepted, altered, forwarded, and / or read by others. When Provider sends you an email or you send Provider an email, the information that is sent is not encrypted.
- You may withdraw this consent at any time by submitting a written request to the Provider. Your consent may be withdrawn except to the extent that action has been taken in reliance on this consent.

Patient's Signature: _____ Date: _____

Print Name: _____ **(when patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required).**

Signature of Legal Representative: _____ Date: _____

Print Name of Legal Representative: _____

Description of Legal Representative Authority: □ Parent □ Medical Power of Attorney (attach documentation)

□ Other _____ (Explain and Attach Documentation)

Panther
PHYSICAL THERAPY

Date: _____

Patient Name: _____Med Rec # / Account#_____

INJURY LIABILITY QUESTIONNAIRE

The nature of your injury may alert your medical insurance company to potential liability. Completing this form in its entirety allows **Panther Physical Therapy** to provide a quick response to those inquiries and prevent delays in processing your claims.

Is this injury work related? □ **Yes** □ **No** **Is this injury auto related?** □ **Yes** □ **No**

Have you/do you intend to file a claim against a business or homeowner's insurance policy? □ **Yes** □ **No**

 **If you answered no to the above questions, it is not necessary to complete the rest of this form. Just sign and date below.**

Date of injury/onset of condition / recent exacerbation? _____

Describe in detail how injury occurred. _____

_____

Specific name & location where injury occurred (IE: store, restaurant, intersection, etc.)

_____

_____

Who is responsible for accident? Self:_____ Other: _____
If other, who? _____

Insurance of responsible party: Name: _____
Address: _____
_____
Claim #: _____
Adjuster Name: _____
Adjuster Phone: _____

Personal insurance: Name:_____
Address: _____
_____
Claim #: _____
Contact Name:_____
Contact Phone:_____

The above information is accurate and true to the best of my knowledge. I agree to immediately notify provider with any change in this information.
Patient's Signature: _____ Date: _____
Print Name:_____(**when patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required).**

Signature of Legal Representative: _____Date: _____
Print Name of Legal Representative: _____
Description of Legal Representative Authority: □ Parent □ Medical Power of Attorney (attach documentation)
□ Other _____ (Explain and Attach Documentation)

Panther
PHYSICAL THERAPY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date :_____

Patient Name: _____Med Rec # / Account#_____

I hereby acknowledge that I have received Notice of Privacy Practices of Provider.

Patient's Signature: _____ Date: _____
Print Name:_____**(when patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required).**

Signature of Legal Representative: _____ Date: _____
Print Name of Legal Representative: _____
Description of Legal Representative Authority: □ Parent □ Medical Power of Attorney (attach documentation)
□ Other _____ (Explain and Attach Documentation)_____
_____

(FOR OFFICE USE ONLY IF PATIENT DOES NOT SIGN ABOVE)
DOCUMENTATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGEMENT

Patient Name:_____

Date:_____
The Patient presented for service on the date set forth above and was provided with a copy of the Notice of Privacy Practices ("Notice"). A good faith effort was made to obtain the Patient's written acknowledgement of receipt of the Notice. However, an acknowledgment was not obtained for the following reason(s):

□ **Patient refused to sign acknowledgement.**

□ **Patient was unable to sign the acknowledgement because:**
_____
_____

□ **Other reason (describe below):**
_____
_____
_____

Name of Employee Completing Form: _____

Signature:_____

Date: _____

Panther
PHYSICAL THERAPY

Patient Name: _____

HOW DID YOU HEAR ABOUT PANTHER PHYSICAL THERAPY?
(Please check ALL that apply.)

- ☐ I am a returning patient
- ☐ Athletic Trainer
- ☐ Chiropractor
- ☐ Direct Mail
- ☐ Facebook
- ☐ Family/ Friends
- ☐ Google
- ☐ Grocery Cart Advertising
- ☐ Health Insurance Company
- ☐ Linked In
- ☐ Magazine Ads
- ☐ Newspaper Ads
- ☐ Panther's Company Website
- ☐ Physician's Office
- ☐ Post-it/ Sticky Notes
- ☐ Sign on Building/ Billboard
- ☐ Radio Ad
- ☐ Yellow Pages
- ☐ Other: _____