Thank you for providing the following information below so that we can provide you the highest quality care and service possible.

Consent: I authorize the medical provider to render Physical Therapy as deemed medically necessary.

Initial _____

Records Release: I authorize the release of any private health information necessary to process my claims or provide continuation of medical care. Initial _____

How did you hear about us? (circle)

DOCTOR RECCOMENDATION WEBSITE GOOGLE YELP SOCIAL NETWORK FRIEND/COLLEAGE

OTHER_____

Cancellation Policy: $50.00 fee for appointment no-shows or Cancellations with less than 24 hours' notice.

Email Policy: We will NEVER give or sell your email address. You can unsubscribe from occasional messages at any time.

Email Address_____ Is it OK to send billing statements to this email? Y N

Appointment Reminders: I would like to receive TEXT reminders:

TEXT MESSAGE: Cell number _____ Cell Carrier name: _____

INJURY DATE_____

Have you received any other physical Therapy this year (2019): Y N

If Yes, how many visits of PT, have you received this year _____

IS YOUR INJURY: (PLEASE CIRCLE) WORK RELATED AUTO RELATED NOT APPLICABLE

ADJUSTER NAME: _____ADJUSTER PHONE NUMBER:_____

ATTORNEY NAME:_____ ATTORNEY PHONE NUMBER:_____

PATIENT NAME: _____ DATE: _____

SIGNATURE: _____

Please circle all that apply

High blood pressure	Heart problems	Shortness of breath
Changes in hair or nails	Diabetes	Low blood sugar
Thyroid problems	Difficulty sleeping while lying flat	Lung problems
Asthma	Ulcers	Cancer
Night sweats	Nausea/vomiting	Bleeding/bruising
Tumors/lumps/bumps	Unexpected weight gain/loss	Long term steroid use
Osteoporosis	Head trauma/Stroke/TIA	Fainting/Blackouts
Change in vision	Dizziness	Balance problems
Ringing in ears	Major dental work	Difficulty eating/swallowing
Change in ability to taste food	Abuse	Vocal changes
Ear pain	Headaches	Mental illness
Numbness/Tingling	Arthritis	Muscle cramps
Broken bones in last year	Surgery	Varicose veins
Hot or cold intolerance	Productive coughing	Contagious disease
Rash	Fever	Bowel or bladder changes
Pelvic inflammatory disease	Difficulty urinating	Blood in urine
Bladder or kidney infection	Abnormal or painful menstruation	Incontinence
Currently pregnant	Current smoker	Alcohol use (how often)

Additional comments/conditions: _____

Why are you here? _____

Prior physical therapy for this condition? _____

What makes this condition **worse**?_____

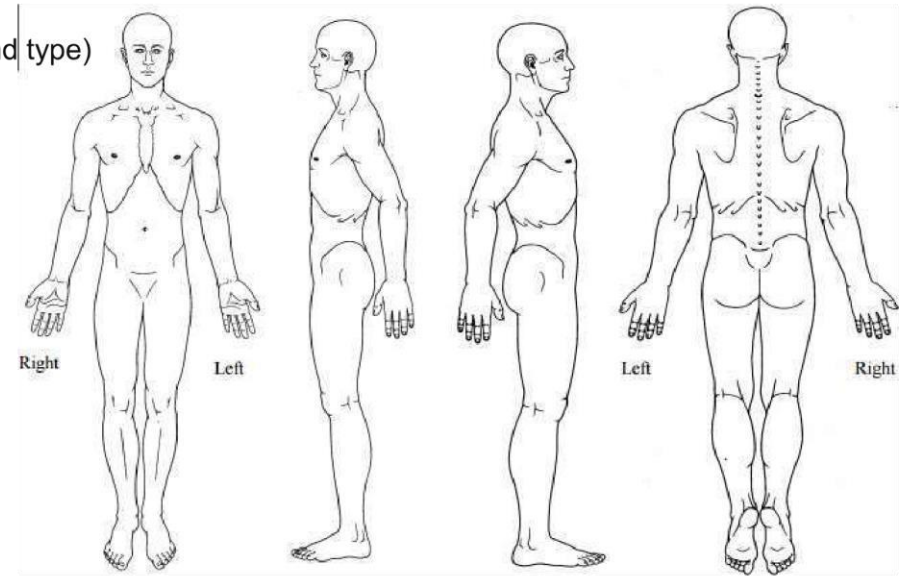
What makes this condition **better**? _____

Current medications: _____

Pain rating Please mark on scale: (NO PAIN)◆·····◆(WORST PAIN EVER)

Pain map (please indicate location and type)

NUMBNESS
****
PINS & NEEDLES
0000
BURNING
XXXX
STABBING
////
ACHING
^^^^



I have stated all my known medical conditions, answered all questions honestly, and agree to keep the therapist updated with changes. There will be no liability on the therapist shall I fail to do so.

SIGN:_____ DATE:_____

Patient Name: _____ Date: _____

Lower Extremity Functional Scale (LEFS)

We are interested in knowing whether you are having any difficulty at all with the activities listed below **because of your lower limb problem** for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, *do you* or *would you* have any difficulty at all with:

	Activities	Extreme difficulty or unable to perform activity	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
1.	Any of your usual work, Housework or school activities.	0	1	2	3	4
2. or	Your usual hobbies, recreational sporting activities.	0	1	2	3	4
3.	Getting into or out of the bath.	0	1	2	3	4
4.	Walking between rooms.	0	1	2	3	4
5.	Putting on your shoes or socks.	0	1	2	3	4
6.	Squatting.	0	1	2	3	4
7.	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8.	Performing light activities around your home.	0	1	2	3	4
9.	Performing heavy activities around your home.	0	1	2	3	4
10.	Getting into or out of a car.	0	1	2	3	4
11.	Walking 2 blocks.	0	1	2	3	4
12.	Walking a mile.	0	1	2	3	4
13.	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14.	Standing for 1 hour.	0	1	2	3	4
15.	Sitting for 1 hour.	0	1	2	3	4
16.	Running on even ground.	0	1	2	3	4
17.	Running on uneven ground.	0	1	2	3	4
18.	Making sharp turns while running fast.	0	1	2	3	4
19.	Hopping.	0	1	2	3	4
20.	Rolling over in bed.	0	1	2	3	4
	Column Totals:					

Total Score: _____/80 = _____% physical function

MEDICARE PATIENTS ONLY
100% - _____% Function = _____% Impairment

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date:_____