Premier
PHYSICAL THERAPY

5008 W. 92nd Ave
Westminster, CO 80031
(303) 412-7035

PATIENT INFORMATION					
First Name:		Last Name:			M.I. :
Birth Date: / /	Age:	☐ Male ☐ Female	Height:	Weight:	
Address:		City:	State:	Zip:	
Cell Phone: ( )		Home Phone: ( )			
Appointment Reminder: ☐ Text Message ☐ Phone Call Preferred Phone Number:					
Email Address:					
I Chose This Clinic Because:					

WORK INFORMATION		
Employer:	Work Phone: ( )	Ext.:
Occupation:	Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION	
Referring Dr.:	Regular Dr.:

INSURANCE INFORMATION	
Name of Primary Insurance:	Name of Secondary Insurance:

AUTO OR WORK INJURY CLAIM (if applicable)			
Insurance Name: ☐ Auto: ☐ Labor & Industries:			
Adjuster/Claim Manager:	Phone: ( )		Ext.:
Address:	City:	State:	Zip:
Claim #:	Accident Date: / /	Cause:	
ATTORNEY INFORMATION			
Name:	Law Firm:	Phone: ( )	
Address:	City:	State:	Zip:

IN CASE OF EMERGENCY	
Name of Emergency Contact:	Relationship to Patient:
Home Phone: ( )	Work Phone: ( )

I authorize my insurance benefits be paid directly to Premier Physical Therapy. I understand that I am financially responsible for my balance. I also authorize Premier Physical Therapy to release any information required to process my claims.

PATIENT/GUARDIAN SIGNATURE **DATE**

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Name: _____

Date: _____

PAST MEDICAL HISTORY

BLOOD PRESSURE	YES	NO
High Blood Pressure		
Low Blood Pressure		

HEART DISEASE	YES	NO
Heart Attack		
Stroke		
Pacemaker		

LUNGS	YES	NO
Asthma		
Emphysema		
Shortness of Breath		
Smoker?		

OTHER CONDITIONS	YES	NO
Muscular Dystrophy		
Rheumatoid Arthritis		
Multiple Sclerosis		
Epilepsy		
Cancer		
Fibromyalgia		
Diabetes		
Hearing Loss		
Poor Eyesight		
Polio		
Joint Replacement		
Osteoporosis		

Other: _____

MEDICATION, SURGERY, INJURY

1. List all current medications you are taking (name, dosage), or attach a list: _____

_____

_____

2. Are you currently taking seizure medicaton? ☐ YES ☐ NO If yes, list name: _____

3. Are you taking any medications that might affect your lungs, heart, consciousness, or general well-being while participating in therapy? ☐ YES ☐ NO If yes, list name: _____

4. List all surgeries in the past two years (include dates):_____

_____

5. Are you pregnant? ☐ YES ☐ NO What week?: _____

6. Have you had any injuries related to work in the last year? ☐ YES ☐ NO

If yes list body part and date: _____

7. Have you had any auto accidents in the last year? ☐ YES ☐ NO

If yes list body part and date: _____

8. Have you had physical therapy within the last year? ☐ YES ☐ NO Where?: _____

9. What are your goals for physical therapy? _____

PATIENT/GUARDIAN SIGNATURE **DATE**

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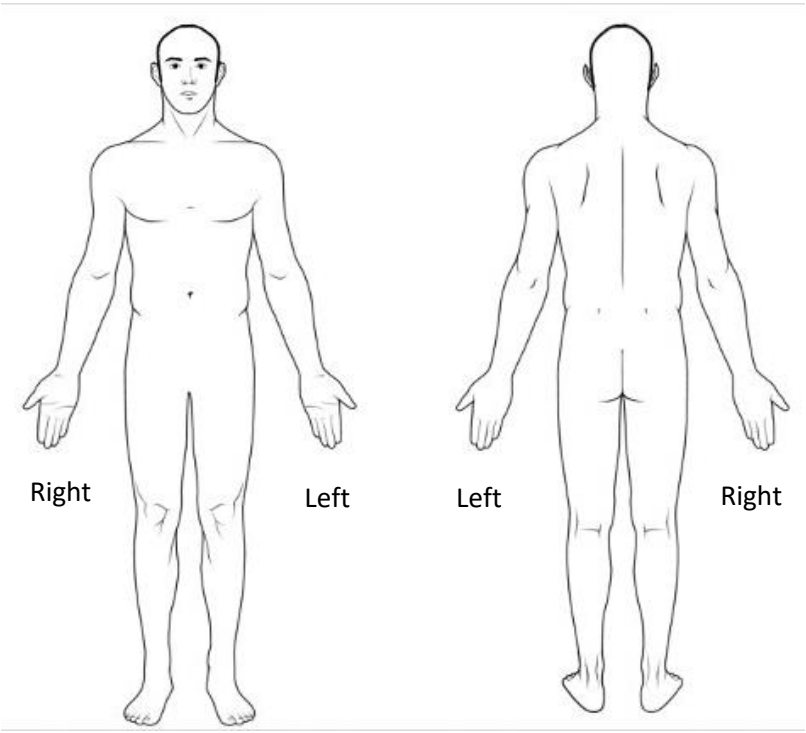
Name: _____

Date: _____

PAIN AND SYMPTOM STATUS REPORT

Circle the area on the body diagram where you are currently experiencing symptoms.



CHIEF COMPLAINT AND VISUAL ANALOG SCALE

My chief complaint is: _____

Date first symptom of your problem occurred on: _____

Please circle on the scale below to indicate your **CURRENT** level of pain:												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it gets

Please circle on the scale below to indicate your **BEST** level of pain:												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it gets

Please circle on the scale below to indicate your **WORST** level of pain:												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it gets

2nd related complaint: _____

Additional comments: _____

_____

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CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information will be used by this practice, known as **Premier Physical Therapy,** or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

We are providing you with a copy of our Notice of Privacy Practices. We request that you review the notice prior to signing this consent. You may request a restriction on the use or disclosure of your protected health information. If you wish to restrict your disclosure, you should make that request in writing.

This practice, however, may or may not agree to restrict the disclosure of your protected health information. If we agree to your request, the restrictions will be binding. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

You may revoke the consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received will not be affected. This practice reserves the right to modify the privacy practices outlined in the notice.

SIGNATURE

I have reviewed this consent form and have reviewed the Notice of Privacy Practices. I give my permission to this practice to use and disclose my health information in accordance with it.

I authorize Premier Physical Therapy to leave appointment information on the following phone numbers:

Cell Number: _____

Home/Work Number: _____

I authorize Premier Physical Therapy to discuss my health information with the following people:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

PATIENT NAME (PRINT)	SIGNATURE	DATE

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INFORMED CONSENT FOR PHYSICAL THERAPY

Physical therapy involves the use of many different types of physical evaluation and treatment. At **Premier Physical Therapy**, we use a variety of procedures and modalities to help us to try to improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

Since the physical responses to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your responses to a certain therapy, modality, or procedure. We are not able to guarantee precisely what your reactions to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggrevate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

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CANCELLATION AND NO-SHOW POLICY

You are coming to physical therapy to remedy the condition that is affecting you; therefore, it is necessary that you attend all of your scheduled appointments.

All missed appointments MUST be made up the same week so you may fully recover.

Premier Physical Therapy requires 24-hour notice for any cancellations. If you no-show or do not give 24 hours of notice 2 times you will be charged a $15.00 fee, and your therapist has the right to discahrge you from our service. You will berequired to follow up with your physician to obtain a new physical therapy referral if you wish to resume physical therapy at our clinic.
We also reserve the right to reschedule your appointment if you are more than 10 minutes late for your scheduled appointment.

PATIENT NAME (PRINT)	SIGNATURE	DATE