FULTZ PHYSICAL THERAPY

(Please Print Clearly)

Patient's First Name: _____ Middle: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ / _____ / _____ Patient's SS#: _____ / _____ / _____ Gender: ❑ Male ❑ Female

Home Phone #: (____)_____ Cell #: (____)_____ Email: _____

Patient's Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other Student: ❑ Part-time ❑ Full-time

Employment Status: ❑ Full-time ❑ Part-time ❑ Unemployed ❑ Self-Employed ❑ Retired ❑ Disabled

Place of Employment: _____ Occupation: _____

Spouse's Name: _____ Spouse's contact #: (_____)_____

Responsible Party / Guardian: (If not the patient; or if patient is a minor (under the age of 18):

First Name: _____ Middle: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ / _____ / _____ SS#: _____ / _____ / _____

Home Phone #: (____)_____ Cell #: (_____)_____

Place of Employment: _____ Work #: (____)_____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Primary Care Physician: _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any and all medical information necessary to process my claim for services provided by Fultz Physical Therapy & Joint Rehab, and request payment of benefits to Fultz Physical Therapy & Joint Rehab, LLC.

I hereby consent to the release and disclosure of my personal health information to Fultz Physical Therapy & Joint Rehab, LLC. This release authorization includes my personal health information consisting of MRI results, test results, etc. for the purpose of deciding plan of treatment.

Patient's / Responsible Party's Signature: _____ Date: _____

MEDICAL HISTORY Date completed: _____/_____/_____

Patient's Name: _____ DOB: _____/_____/_____

Referring Physician: _____ Return Date to Physician: _____

What caused you to seek physical therapy / medical attention? _____

Is your condition related to: ☐Employment ☐Auto Accident ☐Home ☐Other _____

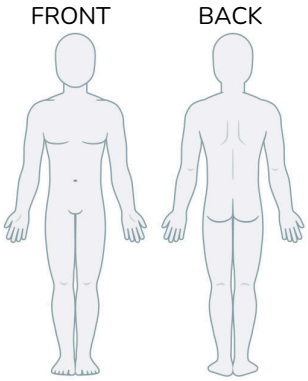
Date of condition / accident: _____ / _____ / _____ State accident occurred: _____

What is your major complaint? Please be as detailed as possible _____

_____

Have you had this problem before? _____Yes _____No

Mark the location of your pain with an "X"



If you have pain, what is your pain level? *please circle* (0 = No Pain, 10 = Extreme Pain)

0	1	2	3	4	5	6	7	8	9	10
No pain										Extreme Pain

What makes your pain better? _____

What makes your pain worse? _____

Is this pain getting: _____ Better _____Worse _____ Not Changing

What type of treatments have you received for this condition?

_____X-rays _____Medications _____CT / CAT Scan _____Physical Therapy

_____Surgery _____Injection _____Home Health

_____Chiropratic _____Bone Scan _____MRI

Please describe (agency, etc.) _____

Have you fallen in the last 12 months? _____Yes _____No If yes, how many times? _____

Did your fall result in an injury? _____Yes _____No _____

PLEASE CHECK ALL OF THE FOLLOWING DIAGNOSED BY A DOCTOR:

___Bronchitis / Emphysema / Lung Disease ___Heart Disease ___Implants

___Pneumonia ___Fibromyalgia ___Lupus

___Abnormal Check X-Ray ___High/Low Blood Pressure ___Tuberculosis

___Chronic Fatigue Syndrome ___Dizziness/Fainting Spells ___Epilepsy

___Thrombosis / Phlebitis ___Muscular Dystrophy ___Pregnant

___Blood-Borne Pathologies: HIV AIDS Hepatitis A Hepatitis B Hepatitis C ___Diabetes

___Tumors/Cancer Year _____ Type _____

___Sprains / Dislocations / Broken Bones - Please list: _____

Please list all medications you are currently taking: _____

_____

Please list any previous surgeries: _____

_____

Height: _____ Weight: _____

Home Health?

Insurance WILL NOT cover outpatient physical therapy while the patient is concurrently receiving ANY Home Health services (i.e.: Doctor, Nursing, Wound Care, Physical Therapy, Occupational Therapy, etc.). If it is determined that you are receiving Home Health while attending outpatient physical therapy, YOU, the patient, are responsible for all charges incurred during your treatment with Fultz Physical Therapy.

If at any time during your treatment at Fultz Physical Therapy, you need Home Health, you will need to stop PT treatment until you are discharged from Home Health.

Are you currently receiving, or in the past 30 days' received,
home medical services? ____Yes ____ No

If yes, when is your Discharge date? _____

Do you have a home health agency providing care at the moment? ____Yes ____ No

Are there any healthcare professionals regularly visiting you at home? ____Yes ____ No

Signature: _____ Date: _____

FULTZ PHYSICAL THERAPY

HIPAA ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

Printed Patient Name: _____

Patient Date of Birth: _____

We at Fultz Physical Therapy & Joint Rehab are required by law to maintain the privacy of health information and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. If you would like a copy of the Notice, please ask.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

_____ _____

Signature of patient or patient's representative/parent Date

_____

Printed name of patient or patient's representative/parent

_____

Relationship to patient