bodywise
PHYSICAL THERAPY & PILATES REHAB

DATE:

**PATIENT INFORMATION**

NAME _____ DOB _____

ADDRESS_____ PHONE_____

_____ EMAIL_____

CHIEF COMPLAINT/AILMENT/INJURY: _____

_____

DATE OF INJURY_____ SURGERY Y / N DATE_____

DESCRIBE MECHANISM OF INJURY_____

ARE YOU INVOLVED IN A LAWSUIT OVER THIS INJURY? ☐ YES ☐ NO

HAVE YOU RECEIVED THERAPY FOR THIS CONDITION? ☐ YES ☐ NO

WHEN/HOW LONG:_____

HAS YOUR CONDITION BEEN GETTING: ☐ WORSE ☐ SAME ☐ BETTER

ARE YOUR SYMPTOMS: ☐ CONSTANT ☐ INTERMITTENT

MARK THE NUMBER THAT BEST CORRESPONDS TO YOUR PAIN:

AT BEST: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

AT WORST: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

WHAT DECREASES/MAKES YOUR CONDITION BETTER? (MARK ALL THAT APPLY)

☐ BENDING ☐ MOVEMENT ☐ REST ☐ MORNING

☐ SITTING ☐ STANDING ☐ HEAT ☐ BETTER AS DAY PROGRESSES

☐ RISING ☐ WALKING ☐ ICE ☐ EVENING

☐ LYING ☐ MEDICATION ☐ CHANGING POSITIONS

WHAT INCREASES/MAKES YOUR CONDITION WORSE? (MARK ALL THAT APPLY)

☐ BENDING ☐ MOVEMENT ☐ REST ☐ WORSE IN AM

☐ SITTING ☐ STANDING ☐ HEAT ☐ WORSE AS DAY PROGRESSES

☐ RISING ☐ WALKING ☐ ICE ☐ WORSE IN PM

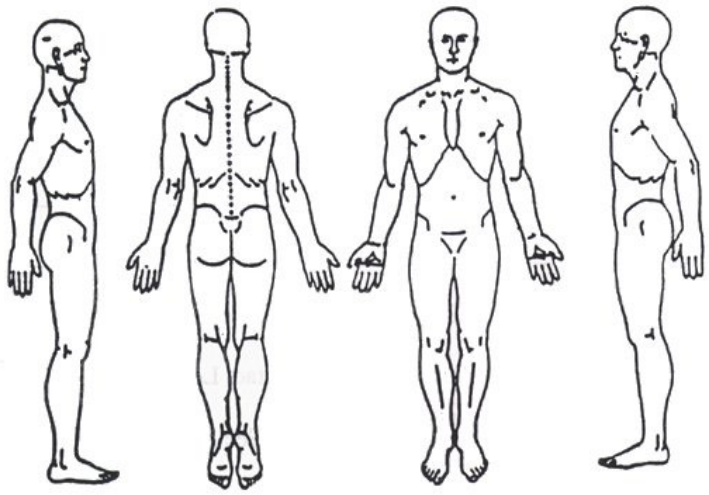
☐ LYING ☐ MEDICATION ☐ CHANGING POSITIONS

DIAGNOSTICS ☐ X-RAY ☐ MRI ☐ CT SCAN ☐ INJECTIONS DATES: _____

WHAT ARE YOUR GOALS FOR THERAPY? _____

DRAW IN AREAS OF PAIN ON BODY DIAGRAMS USING APPROPRIATE SYMBOL:

SHARP (XX) NUMB/TINGLING (++) DULL/ACHY (##) BURNING (BB)



MEDICAL INFORMATION: (MARK ALL THAT APPLY):

| | | |
|---|---|---|
| ☐ DIFFICULTY SWALLOWING | ☐ STROKE | ☐ OSTEOPOROSIS |
| ☐ HIGH BLOOD PRESSURE | ☐ ARTHRITIS | ☐ FEVER/CHILLS/SWEATS |
| ☐ BOWEL/BLADDER PROBLEMS | ☐ HEART DISEASE | ☐ PACEMAKER |
| ☐ DIZZINESS/BLACKOUTS | ☐ BLOOD CLOTS | ☐ HIV/HEPATITIS |
| ☐ NAUSEA/VOMITING | ☐ DIABETES | ☐ DEPRESSION/ANXIETY |
| ☐ PREGNANCY | ☐ FIBROMYALGIA | ☐ CANCER |
| ☐ SMOKER | ☐ MEMORY LOSS | ☐ MUSCLE CRAMPING |
| ☐ OTHER: | | |

PREVIOUS SURGERIES: _____

MEDICATIONS:_____

_____

ALLERGIES: _____

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# Financial Policy and Medical Assignment of Benefits

Bodywise Physical Therapy & Pilates Rehab is dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with us prior to beginning your care.

- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for services are due at the time of service.
- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees, and court fees shall become your responsibility in addition to the balance due this office.
- There is a $20.00 service fee for all returned checks.
- If cancellations are not made **24 hours** in advance, you will be charged the price of the full session.

Participant's name (Printed)_____

Participant's Signature _____Date_____

## Protected Health Information

Your protected Health information will be used by Bodywise Physical Therapy & Pilates Rehab or disclosed to others for the purposes of treatment, obtaining payment or supporting the day to day health care operations of this office. You may request a copy of the Notice of Privacy Practices from our office at any time. You may request to restrict the use of your Protected Health Information with this office. This office reserves the right to modify its privacy practices at any time.

By signing below, I am agreeing that I am fully aware of my rights to my Protected Health Information and authorize Bodywise Physical Therapy & Pilates Rehab to email me in regards to health information.

Participant's Signature _____Date_____