



**KINDLY GIVE AT LEAST 24 HOURS NOTICE FOR CANCELLATION OR RESCHEDULING.** Please be aware to give 24 hours notice if you are unable to attend your appointment or it will result in a \$30.00 charge.

**PLEASE BE TIMELY FOR APPOINTMENTS.** If you arrive more than 15 minutes late for your scheduled appointment, you may have to be rescheduled. This is for the benefit of you and other patients being treated.

**WHEN ABLE, PLEASE SCHEDULE YOUR APPOINTMENTS ONE WEEK IN ADVANCE TO ENSURE THE TIMES THAT YOU NEED.** Appointment times given one week do not automatically follow through to the subsequent weeks.

The patient and therapist have discussed the importance of frequency and duration.

**THANK YOU FOR YOUR COOPERATION.**

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**Patient Signature**

**Date**

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**Therapist Signature**

**Date**



**PATIENT INFORMATION**

(Please complete both sides of form)

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Name \_\_\_\_\_  
(First) (Last) (Middle)

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Birth Date \_\_\_\_\_

Social Security # \_\_\_\_\_ E-Mail \_\_\_\_\_

For updates, seminars, event notices

Marital Status M  S  W  Sex M  F

**EMPLOYMENT INFORMATION**

Employer / School \_\_\_\_\_ Occupation \_\_\_\_\_ Dept. \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**CORE FINANCIAL POLICY**

- Patients with health insurance should remember that services rendered are charged to you, the patient, not your insurance company.
- As a courtesy to our patients, we will verify your insurance coverage and benefits (\*Verification is only a quote) as well as file therapy claims for you, however we do not accept the responsibility for settling the claim with your carrier.
- If payment is delayed, reduced or denied, you will be responsible for settling your balance with us.
- We require 24-HOUR NOTICE for any cancellation. A \$30.00 fee will be charged to your account for failure to comply.

**TREATMENT AUTHORIZATION**

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Your signature is required below to authorize treatment. Your signature also authorizes the release of medical information needed to process your claim, allowing an assignment of benefits where a claim has been filed, and acknowledging your understanding of the above office policies. An additional treatment authorization signature is required by a parent / legal guardian for all minors.

\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_  
Parent or Guardian Signature / Print Full Name Date

**HIPAA AUTHORIZATION**

In compliance with HIPAA regulations, I authorize the following individuals to receive verbal information regarding the billing of my account.

\_\_\_\_\_  
Name / Relationship Name / Relationship Name / Relationship



## OUTPATIENT SCREENING FORM

Please answer all questions to the best of your ability.

1. Patient Name: \_\_\_\_\_
2. Age: \_\_\_\_\_      3. Height: \_\_\_\_\_      4. Weight: \_\_\_\_\_
5. What problem are you being treated for today? \_\_\_\_\_
6. When did your problem begin? \_\_\_\_\_
7. Have you received treatment for these symptoms? *Please check:* Yes    No  
If yes, what type? \_\_\_\_\_
8. Have you received physical/occupational therapy within the last calendar year? *Please check:* Yes    No  
If yes, was it for your current problem? *Please check:* Yes    No  
Approximately how many treatment sessions have you received this calendar year? \_\_\_\_\_
9. Are you currently working? *Please check:* Yes    No    *Please check:* Light Duty    Full Duty    Not Working
10. What is your occupation? \_\_\_\_\_
11. Does your occupation consist of:      Sitting\_\_\_\_      Standing\_\_\_\_      Walking\_\_\_\_      Lifting\_\_\_\_
12. Are you currently taking any medications: *Please check:* Yes    No  
If yes, please list medications: \_\_\_\_\_
13. Do you have any known drug allergies? *Please check:* Yes    No  
Please list: \_\_\_\_\_
14. Have you had any surgeries or significant past medical history? *Please check:* Yes    No  
If yes, please list: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
15. What kind of testing have you received for this problem?  
*Please check:* X-ray    MRI    CT Scan    Bone Scan    Other  
If yes, please explain results: \_\_\_\_\_

16. Please place a CHECK next to any conditions that you have experienced in the PAST. CIRCLE any condition that you have CURRENTLY.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Bone or joint disease    | <input type="checkbox"/> Thyroid problems              | <input type="checkbox"/> High blood pressure       |
| <input type="checkbox"/> Tendonitis/bursitis      | <input type="checkbox"/> Lymphedema                    | <input type="checkbox"/> Low blood pressure        |
| <input type="checkbox"/> Broken/fractured bones   | <input type="checkbox"/> Kidney problems               | <input type="checkbox"/> Pacemaker                 |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Irritable Bowel Syndrome      | <input type="checkbox"/> Metal Implants            |
| <input type="checkbox"/> Spasms/cramps            | <input type="checkbox"/> Herpes/shingles               | <input type="checkbox"/> Are you pregnant?         |
| <input type="checkbox"/> Sprains/strains          | <input type="checkbox"/> Sleep disorders               | <input type="checkbox"/> Rashes                    |
| <input type="checkbox"/> Low back, hip, leg pain  | <input type="checkbox"/> Depression                    | <input type="checkbox"/> Athlete's foot            |
| <input type="checkbox"/> Neck, shoulder, arm pain | <input type="checkbox"/> Psychological                 | <input type="checkbox"/> Warts                     |
| <input type="checkbox"/> Headaches/head injuries  | <input type="checkbox"/> Eating disorder               | <input type="checkbox"/> Bladder problems          |
| <input type="checkbox"/> Jaw pain/TMJ             | <input type="checkbox"/> Drug/alcohol addiction        | <input type="checkbox"/> Urinary tract infection   |
| <input type="checkbox"/> Lupus                    | <input type="checkbox"/> Nicotine/caffeine addiction   | <input type="checkbox"/> Nausea/vomiting           |
| <input type="checkbox"/> Aids/HIV                 | <input type="checkbox"/> Hypoglycemia                  | <input type="checkbox"/> Gas/bloating/constipation |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Varicose veins                | <input type="checkbox"/> Allergies/skin allergies  |
| <input type="checkbox"/> Seizures                 | <input type="checkbox"/> Blood clots                   | <input type="checkbox"/> Numbness/tingling         |
| <input type="checkbox"/> Cancer/tumors            | <input type="checkbox"/> Breathing difficulties/asthma | <input type="checkbox"/> Fatigue                   |
| <input type="checkbox"/> Heart condition          | <input type="checkbox"/> Sinus problems                |  |
|   | <input type="checkbox"/> Chest pain                    |  |

If you checked/circled any of the above, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

17. During the past month, have you been bothered by feeling down, depressed, or hopeless? *Please check: Yes No*

18. During the past month, have you been bothered by having little interest or pleasure in doing things? *Please check: Yes No*

19. Is there anything else we should know that is pertinent to your treatment? \_\_\_\_\_  
\_\_\_\_\_

20. What is your goal you would like to achieve from therapy? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

21. Do you exercise regularly? *Please check: Yes No*  
If yes, what is your primary activity? \_\_\_\_\_

22. What is your primary language? \_\_\_\_\_  
If other than English, will you be providing a translator? \_\_\_\_\_

23. Person to contact in case of an emergency if no one is at your home phone number:  
Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_