

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Email: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Emergency Contact (name, phone number, relationship): \_\_\_\_\_

**Medical History**

List all medications (prescription & non-prescription): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List all allergies: \_\_\_\_\_

Have you had a fall in the past year? (circle) YES NO

Do you now or have you ever had any of the following? Please include all history:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Coronary Heart Disease   | <input type="checkbox"/> Asthma/Bronchitis/Emphysema | <input type="checkbox"/> Sleeping difficulty     |
| <input type="checkbox"/> Pacemaker                | <input type="checkbox"/> Epilepsy or seizures        | <input type="checkbox"/> Weakness                |
| <input type="checkbox"/> Shortness of breath      | <input type="checkbox"/> Thyroid disease             | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> High/low blood pressure  | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Fatigue                 |
| <input type="checkbox"/> Stroke/TIA/Blood clot    | <input type="checkbox"/> Gout                        | <input type="checkbox"/> Depression/anxiety      |
| <input type="checkbox"/> Chest pain (angina)      | <input type="checkbox"/> Osteoporosis                | <input type="checkbox"/> Shoulder injury         |
| <input type="checkbox"/> Heart attack             | <input type="checkbox"/> Bowel/bladder changes       | <input type="checkbox"/> Back injury             |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Numbness or tingling        | <input type="checkbox"/> Elbow/hand injury       |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Vision/hearing problems     | <input type="checkbox"/> Knee injury             |
| <input type="checkbox"/> Pins or metal implants   | <input type="checkbox"/> Arthritis                   | <input type="checkbox"/> Neck injury             |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Dizziness                   | <input type="checkbox"/> Foot/ankle injury       |
| <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Are you pregnant?           | <input type="checkbox"/> Hip injury              |
| <input type="checkbox"/> Do you smoke?            |  |  |

Surgical history (including year): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient Health Questionnaire**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Describe your symptoms: \_\_\_\_\_  
\_\_\_\_\_

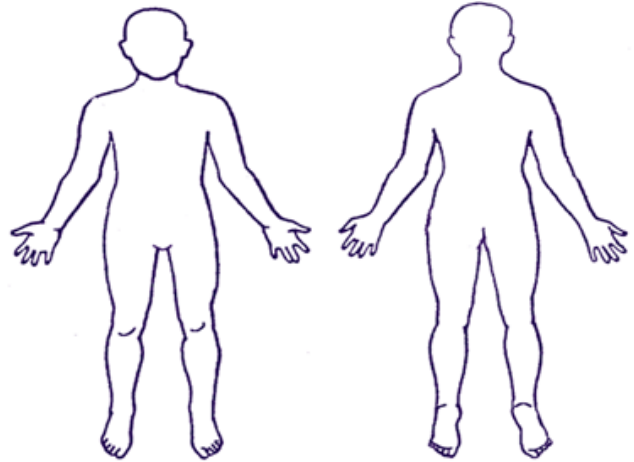
When did your symptoms start? \_\_\_\_\_

How did your symptoms start? \_\_\_\_\_

Indicate below where you have pain or symptoms:

How often do you experience your symptoms?

- Constantly (75-100% of the day)
- Frequently (50-75% of the day)
- Occasionally (25-50% of the day)
- Intermittently (0-25% of the day)



What describes your symptoms?

- Sharp     Shooting     Dull ache
- Burning     Throbbing     Numb/tingling

How are your symptoms changing? (circle)

- Getting better    Getting worse    Not changing

During the last month:

1. Circle the average intensity of symptoms: (none) 0 1 2 3 4 5 6 7 8 9 10 (severe)
2. How much has pain interfered with your normal work (including housework and occupation)?
  - a.  Not at all     A little bit     Moderately     Quite a bit     Extremely
3. How much of the time has your condition interfered with your social activities?
  - a.  Not at all     A little bit     Some of the time     Most of the time     All the time

In general, how would you describe your current overall health?

- Excellent     Very good     Good     Fair     Poor

What have you tried to improve your symptoms?

- Physical therapy     Chiropractic     Medical doctor     Injections     Cold/hot packs
- CBD/alternative     Medication     Other: \_\_\_\_\_

What tests have you had for your symptoms and when were they performed?

X-rays: \_\_\_\_\_ MRI: \_\_\_\_\_ CT scan: \_\_\_\_\_ Other: \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Acknowledgment of Notice of Privacy Practices**

\_\_\_\_ (Initial) I acknowledge and agree that I have been informed to read the Notice of Privacy Practices Policy on THE PHYSICAL THERAPY INSTITUTE’s website. In addition, I acknowledge I can request a copy of the Notice of Privacy Practices in writing at any time.

**Acknowledgment of Surprise Billing Disclosure**

\_\_\_\_ (Initial) I acknowledge and agree that I have been informed to read the Surprise Billing Disclosure on THE PHYSICAL THERAPY INSTITUTE’s website. In addition, I acknowledge I can request a copy of the Surprise Billing Disclosure in writing at any time.

**Cancelation and No-Show Policy**

\_\_\_\_ (Initial) It is the patient’s responsibility to give THE PHYSICAL THERAPY INSTITUTE at least 24 hours’ notice if they are unable to attend an appointment. All efforts will be made to reschedule a canceled appointment within the same week to stay on the patient’s recommended plan of care. Our time is valuable to our patients and this policy allows us to offer appointments to all patients in a timely and effective manner. If a patient has 3 or more canceled or no-showed appointments, they will be changed to “Day-Of Scheduling” status and not allowed to schedule appointments on future days.

**Informed Consent**

“Informed Consent” is a process for getting permission before we provide therapeutic services to you, the patient. A sound informed consent includes an explanation of the potential risks, benefits, and alternatives to any treatment that has been proposed to you or, in the case of a minor, your representative. We will discuss the Plan of Care established for you and give you ample time to ask questions about it; your consensus is a critical part of achieving a successful outcome.

**Potential Benefits:** You may experience improvement in your symptoms and functional activities as well as resolution of other key complaints or problems. In addition to treatment, we provide education to you about your condition throughout your episode of care. This education is often accompanied by handout material that you can refer to regarding proper techniques and home program execution. These resources will help you maintain a sound level of function and will also help you minimize symptoms, should they reoccur.

**Potential Risks:** You may experience an increase in your current level of pain, if pain is part of your complaints. Many times increased activity or therapy interventions will bring on some discomfort, this is usually temporary. If your pain or discomfort does not subside within twenty-four (24) hours, you should discontinue any home program involving that particular activity, if applicable, and contact your therapist.

**Alternatives:** We establish a Plan of Care based on the best interventions for your condition, but on occasion our choice of treatment is not well tolerated. You are asked to voice any unfavorable reaction you experience to any aspect of your treatment so that we can modify or terminate it promptly and progress your rehabilitation. If you decide not to continue your participation in your therapy program you will be asked to consult with your physician about other treatment alternatives.

**No Warranty:** Please note that we cannot make any promises or guarantees regarding a full resolution of and/or correction of your condition. We will, however, work in conjunction with you to achieve optimal improvement.

**I have read the above information, and I consent to the evaluation(s) and treatment provided by The Physical Therapy Institute**

Name: \_\_\_\_\_

Signature: \_\_\_\_\_  
PTI\_2025

Date: \_\_\_\_\_