# Returning Patient Update

Please write down any changes in the following:

Address_____

Insurance_____

Medication_____

Other (allergies, hospitalizations, etc)_____

Primary Care Physician_____Referring Physician_____

Seeking treatment for_____Pain Onset/Injury Date_____

Any imaging (X-Ray/MRI) relating to the area of concern? Yes No If so, where and when?_____

Are you receiving or have you recently received home health services? ☐ Yes ☐ No

Are you receiving or have you recently received other therapy services? ☐ Yes ☐ No

If "Yes", please explain_____

Please list any new (since past visit) surgeries or other conditions for which you have been hospitalized:

Could you be, or are you, pregnant? ☐ Yes ☐ No

Please check any of the following which you have recently noticed:

☐ Weight loss/gain ☐ Nausea/vomiting ☐ Fatigue ☐ Weakness ☐ Fever/chills/sweats ☐ Numbness/tingling

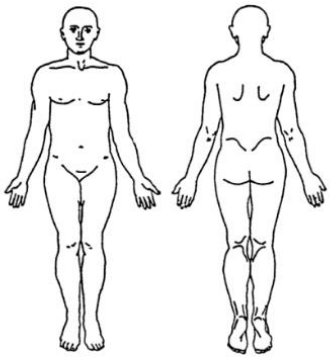
Which of the following conditions are you currently being treated or have been treated for in the past? (please check)

- ☐ Cancer
- ☐ Other arthritic conditions
- ☐ Depression
- ☐ Anxiety
- ☐ Tuberculosis
- ☐ Kidney disease
- ☐ Epilepsy/Seizures
- ☐ High/Low blood pressure
- ☐ Asthma
- ☐ Pacemaker
- ☐ Diabetes
- ☐ Shortness of breath
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Hepatitis
- ☐ Stroke
- ☐ Anemia
- ☐ Heart problems
- ☐ Circulation problems
- ☐ Emphysema/Bronchitis
- ☐ Thyroid problems
- ☐ Multiple sclerosis
- ☐ Recent weight loss/gain
- ☐ Latex Allergy

If you checked any of the above or have other conditions not listed, please explain:

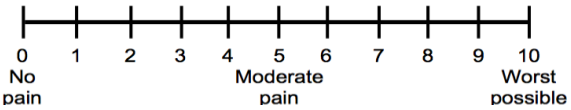
_____

Circle the parts of the body that are currently giving you discomfort:

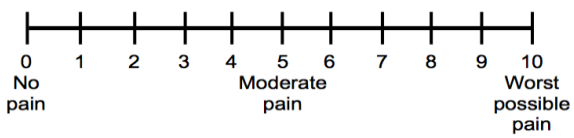


Using the scales below, indicate your pain levels by circling the appropriate number on the following scales.

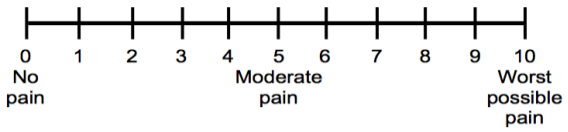
Please rate your **current** level of pain:




Please rate your **worst** level of pain in the last 24 hours:




Please rate your **best** level of pain in the last 24:



# Patient Authorization

## Release of Information and Consent for Treatment

All information provided herein is true and correct. I am aware of my diagnosis and wish to receive treatment at ProTailored Physical Therapy, LLC. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing, and treatment. No guarantees have been made to me about the outcome of this care.I give permission to ProTailored Physical Therapy, LLC to release information, verbal and written, contained in my medical record and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related health care provider, assignees, beneficiaries, and/or all other related persons as it relates to my treatment and/or payment for services provided.
I authorize ProTailored Physical Therapy, LLC to obtain medical records and/or professional information from my physician and/or other medical professional as it relates to my treatment.
The initials below certify that I have read and understand the above information:
**Initial_____**

## Notice of Privacy Practices
## (HIPPA Acknowledgement/Consent)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for ProTailored Physical Therapy, LLC. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations. I understand the risks associated with the use of email and text messaging as a form of communication between the ProTailored staff and me, as well as any other instructions that ProTailored may impose to communicate with me by email or text message. I consent to ProTailored sending me letters via email. Emails are sent through the MailChimp email service. I understand that they are sent via a public network to a personal email address and as such may not be secure. I agree to advise the practice if my email address changes.
**Initial_____**

## Missed Appointment Policy

**All appointments require a 24-hour cancellation notice to avoid a $50 missed appointment fee.**

We, along with your physician, have given time and thought to your treatment plan, but it will not work if you are not here. Your therapist is committed to your recovery and has reserved a 40 minute one-on-one block of time in their schedule for each appointment you make; we expect the same commitment from you by keeping your scheduled appointments as this can mean the difference between whether you succeed in therapy or not. Please attend your appointments on time, as tardiness not only affects your care, but the care of others. If you know you are going to be more than 10 minutes late, PLEASE CALL. You will be charged a $50 administrative fee (which is not refunded by insurance) for not showing up to your appointment or cancelling with less than a 24 hour notice. If you do not show up to two or more of your appointments, services may be discontinued due to non-compliance.

I affirm the information above is correct, and I understand the missed appointment policy

_____

Signature of Patient or Responsible Party Date

I certify that I have read, understood, and filled out all the information in this packet accurately to the best of my knowledge:

**Patient Name_____Patient/Guardian Signature_____Date_____**