



Name: \_\_\_\_\_  
Last First Middle Initial

Address: \_\_\_\_\_

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

Gender: Male  Female  Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Primary Phone: (\_\_\_\_\_) \_\_\_\_\_ appt text reminders to this phone? Yes

Secondary Phone: (\_\_\_\_\_) \_\_\_\_\_ appt text reminders to this phone? Yes

Email: \_\_\_\_\_ appt email reminders to this email? Yes

Referring Physician: \_\_\_\_\_

Next appointment with Referring Physician \_\_\_\_\_

Have you received physical therapy this year? Yes  No  If yes, where at? \_\_\_\_\_

**MEDICARE PATIENTS:** Are you currently receiving home health services? Yes  No

If yes, name of the Agency providing services \_\_\_\_\_

***ALL NEW PATIENTS – Please complete the following section:***

**Primary Insurance Company:** \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Patient Relation to Policy Holder \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Patient Relation to Policy Holder: \_\_\_\_\_

***Please complete this section ONLY IF On The Job Injury / Worker's Compensation Claim:***

Insurance Name: \_\_\_\_\_ Claim # \_\_\_\_\_

Employer: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Case Manager: \_\_\_\_\_ Phone No: \_\_\_\_\_

Employer Phone No: \_\_\_\_\_



## Symptom Sheet

Name \_\_\_\_\_ Date \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Describe your problem \_\_\_\_\_

Was this from an accident? No  Yes  Date \_\_\_\_\_

If **yes**, was it related to: Auto \_\_\_\_\_ On the job injury \_\_\_\_\_ Other \_\_\_\_\_

Have you had this problem before? Yes  No

Have you had Physical Therapy for this problem before? Yes  No

What time of day are your symptoms worse? \_\_\_\_\_ better? \_\_\_\_\_

Do you have problems getting to sleep? Yes  No  Staying asleep? Yes  No

Do you have any of the following symptoms? **(circle all that apply)**

Headaches                      Weakness                      Numbness                      Tingling                      Dizziness

Pain                      Muscle Spasms                      Decreased Motion                      Other \_\_\_\_\_

Which of the following activities increases your symptoms? **(circle all that apply)**

Coughing                      Sneezing                      Swallowing                      Lying on back                      Lying on front

Urinating                      Bowel Movements                      Bending Forward                      Other \_\_\_\_\_

Which of the following decreases your symptoms? **(circle all that apply)**

Heat                      Ice                      Massage                      Exercise

Have you had any diagnostic tests taken for this problem? **(circle all that apply)**

X-rays      MRI      CT Scan      Bone Scan      Nerve Conduction      Other: \_\_\_\_\_

Are you taking medications for this problem? \_\_\_\_\_

Do you have any other medical conditions? \_\_\_\_\_

Are you taking any medications for these conditions? \_\_\_\_\_

Are you currently off work due to your Physical Therapy problem? Yes  No  Not employed



## INFORMED CONSENT

I consent to receiving physical therapy services which are deemed medically necessary by my referring and/or primary care physician. I authorize the release of medical information to my referring physician and insurance company.

I am aware that Three Rivers Physical Therapy will submit charges for services to my insurance company unless I make other arrangements. I hereby assign all medical benefits to be paid directly to Three Rivers Physical Therapy. I realize I am responsible for all charges incurred, regardless of payment by my insurance company. Any charges not paid by my insurance company will become my responsibility within 60 days. If it becomes necessary for my account to be assigned to a collection agency, I agree to pay all collection costs.

I assign any proceeds from any cause of action, whether from a court award or settlement, in the hands of my attorney, the responsible party, or the insurance carrier for the responsible party to Three Rivers Physical Therapy. I authorize and direct my attorney to pay all outstanding bills to Three Rivers Physical Therapy from the proceeds of any settlement.

**I understand that there may be a twenty dollar (\$ 20.00) handling fee for "no shows" and cancellations of more than 2 appointments without providing twenty-four (24) hour notice.**

**I authorize the use of this signature on all insurance submissions.**

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

A copy of Three Rivers Physical Therapy's **Notice of Privacy Policies** has been made available to me, detailing how my information may be used and disclosed as permitted under federal and state law. I permit a copy of this authorization to be used in place of the original. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

Restriction(s): \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

**Patient or Representative Signature**

\_\_\_\_\_

**Date**

If not signed by patient, please indicate relationship to patient (e.g., spouse, parent)

Relationship: \_\_\_\_\_