BRYANT ORTHOPEDIC
& SPORTS PHYSICAL THERAPY
Move More, Live Strong

MEDICAL HISTORY QUESTIONNAIRE

Patient Information

Name:_____ Date of Birth:_____ Gender:_____
Cell Phone:_____ Email:_____
Address:_____ City:_____ State:_____ Zip:_____

Emergency Contact

Name:_____ Relationship:_____
Cell Phone:_____

Employer Information *(Workers Comp only)*

Occupation:_____ Company:_____
Contact Name:_____ Work phone:_____

Have you been a patient here before?_____
Is this a sports related injury?_____

-If yes, list school and sport _____

COVID QUESTIONNAIRE

1. Have you or anyone in your household had any of the following symptoms in the last 14 days: **Sore throat, Cough, Chills, Body Aches for unknown reasons, Shortness of breath for unknown reasons, Loss of smell, Loss of taste, Fever OVER 100 degrees**? **NO or YES**
2. Have you or anyone in your household been tested for COVID-19? **NO or YES**
    a. If **YES**, explain results of test: _____
2. Have you or anyone in your household visited or received treatment in a hospital, nursing home, long-term care, or other health care facility in the past 30 days? **NO or YES**
3. Have you or anyone in your household traveled in the U.S. in the past 21 days? **NO or YES**
4. To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19? **NO or YES**
5. Have you or anyone in your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19? **NO or YES**
6. Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19?

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Referring Physician:_____ Phone Number:_____

Primary Care Physician:_____ Phone Number:_____

Current Medical History

Date of Injury: _____

Type of Injury: Work related/Auto Accident (Private or Auto Insurance)/Sports Related/Other
(*Please Circle One)*

Medications:

_____

_____

Do you smoke? (*Please Circle One)* YES NO

Are you pregnant? (*Please Circle One)* YES NO

Please check all that apply and explain medical problems you have or previously had:

- o Asthma
- o Diabetes
- o Cancer
- o Kidney Disease
- o Epilepsy
- o Seizures
- o High Blood Pressure
- o Thyroid Disease
- o Surgery
- o Stroke
- o Latex Allergy
- o Fractures
- o Hepatitis A/B/C
- o Chest Pain
- o AIDS/HIV
- o Back Trouble
- o Shortness of Breath

_____

_____

Allergies:_____

To the best of my knowledge, all of this information of Medical History is correct.

Patient Signature:_____ Date:_____

Parent/Authorized Individual Signature if needed:_____

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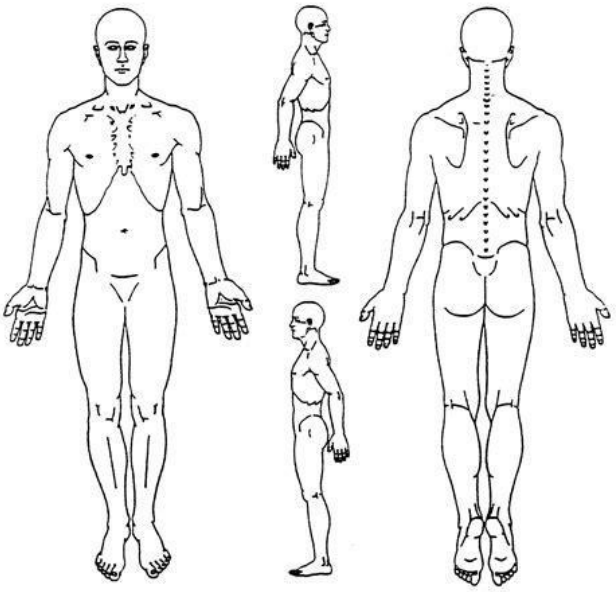
Please mark where you feel symptoms related to your current condition.



Pain Quality:

- o Dull Aching
- o Sharp/Stabbing
- o Numbness/Tingling
- o Burning

Changing degree of pain:

- o Improving
- o Staying the same
- o Worsening

Are you awakened at night from this pain?

- o Yes, how often_____
- o No

I feel my best

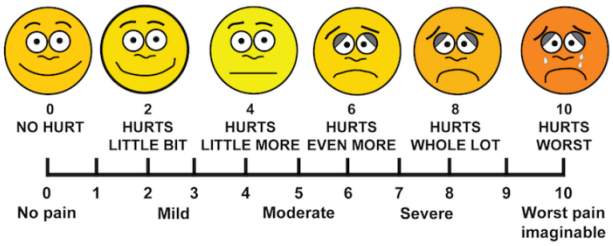
- o Morning
- o Evening
- o Constant pain

List 3 current problems for your visit today:

1. _____
2. _____
3. _____

Please circle your pain within the past 48 hours.

PAIN MEASUREMENT SCALE



Physical Limitations

***Within the past week, select the best answer as it relates to your current symptoms.**

Dressing Tolerance

- o Unable
- o Increases Pain
- o No Pain

Sitting Tolerance

- o Unable
- o Increases Pain
- o No Pain

Driving Tolerance

- o Unable
- o Increases Pain
- o No Pain

Social Life

- o Unable to participate
- o Increases Pain
- o No Pain

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PATIENT COMMITMENT & MISSED APPOINTMENT POLICY

Dear Patient,

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and gain of your physical abilities is something everyone in our clinic takes quite seriously.

Because we care so much about you we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we have certain rules that need to be followed in order to ensure the most optimum results. It is expected that you keep all your scheduled appointments.

What to wear on your first day of therapy: Get ready to move a lot during the first physical therapy session. Ensure to wear clothing you can move freely and secure in. When you're choosing your clothing for your physical therapy session, you also need to consider the part of your body the therapist will work on. Here are some of the common clothing items you can choose for a typical physical therapy appointment:

- **Clothing designed for working out:** You can wear t-shirts, yoga pants, appropriate gym shorts or appropriate tank tops. (wearing revealing clothing is prohibited)
- **Sports shoes:** You can wear gym shoes, trainers or running shoes. Sandals and Crocs are typically not recommended unless instructed to do so by your therapist.

A 24 hours' notice is required for an appointment to be rescheduled. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. This appointment needs to be in the same week of the original appointment, preferably the very next day. In an instance of a cancellation without 24 hours' notice or no-show to a scheduled appointment, we reserve the right to charge a **$50 fee**.

The only exception to the cancellation fee is in the case of an emergency. If repeated cancellations of more than 2 sessions, we reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We greatly appreciate you as a patient and strive to accomplish wonderful results and success for you.

By signing this you acknowledge, understand and agree to the above policies.

Print Name:_____ Date:_____

Signature:_____ Date:_____

Parent/Authorized Individual Signature if needed:_____

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APPOINTMENT REMINDER CONSENT FORM

As a courtesy to our patients, we provide appointment reminders via text or email. Our goal is to provide you with the most convenient reminders for your appointments.
If you would like to utilize this feature, please read and sign this consent form. If you would prefer not to take part in our appointment reminder system, please feel free to leave this form blank.

Select one option below:

- o **EMAIL REMINDER** Bryant Orthopedic and Sports Physical Therapy may send email messages to confirm my upcoming appointments.

  My email address is:_____

- o **TEXT REMINDER** Bryant Orthopedic and Sports Physical Therapy may send cell phone text messages to confirm my upcoming appointments.
  My cell phone number is:_____
  I recognize that normal text messaging rates may apply.

Print Name:_____ Date:_____

Signature:_____ Date:_____

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CONSENT TO TREATMENT & THERAPEUTIC PROCEDURES

I hereby consent to the therapeutic procedures outlined below, to be performed by Bryant Orthopedic and Sports Physical Therapy.

I agree to be evaluated and treated for functional loss due to related nerve, muscle, and skeletal dysfunctions and/or pain. I understand that therapeutic procedures can include, but are not limited to: joint and soft tissue mobilization, home exercise programs, functional training including: posture and body mechanics, modalities, such as heat, ice, electrical stimulation, and ultrasound, and special procedures such as: taping, neuromuscular electrical stimulation, and bladder training. I understand that I will be explained the purpose of the therapeutic procedures prior to receiving treatment and that I may refuse any therapeutic procedure or treatment at any time. I understand that I may consult with other therapists and/or physicians at any time regarding my condition. I understand that I may purchase exercise equipment from Bryant Orthopedic and Sports Physical Therapy or from any other source.

Please note: We are a privately owned company and reserve the right to refuse services to any patient: Including rude or angry guests, patients with inappropriate clothing, those not willing to comply with CDC guidelines, patients with open and leaking wounds outside our PT scope of practice

By signing below you are certifying that you have read,understand and agree to the above statements and/or policies set forth in the patient intake.

FINANCIAL RESPONSIBILITY POLICY

I hereby agree to pay my account AS SERVICES ARE PROVIDED. If for any reason there is a balance owing on my account, I will pay promptly upon receipt of the statement. In exceptional circumstances, an extended payment plan may be arranged through Bryant Orthopedic and Sports Physical Therapy billing department. These arrangements must be completed within 10 days of my initial visit to the office. I hereby assign all physical therapy benefits to Bryant Orthopedic and Sports Physical Therapy. I understand that if my insurance benefits and/or eligibility DO NOT COVER OR APPROVE PAYMENT FOR SERVICES PROVIDED BY BRYANT ORTHOPEDIC AND SPORTS PHYSICAL THERAPY, THEN I AM FINANCIALLY RESPONSIBLE AND AGREE TO PAY FOR ALL CHARGES RELATED TO THE SERVICES PROVIDED. This includes, but not limited to, services deemed 'non-covered' or 'not medically necessary' by my insurance.

Although I have requested Bryant Orthopedic and Sports Physical Therapy to bill my insurance company on my behalf, I CLEARLY UNDERSTAND THAT I AM RESPONSIBLE DIRECTLY TO BRYANT ORTHOPEDIC AND SPORTS PHYSICAL THERAPY FOR MY ACCOUNT REGARDLESS OF THE STATUS OF MY INSURANCE CLAIM. I also understand a $25.00 fee will be charged for all checks returned unpaid.

Patient's Signature:_____ Date:_____

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT SUMMARY OF NOTICE OF PRIVATE PRACTICES

This summary is provided to assist you in understanding the Notice of Privacy Practices
The Notice of Privacy practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to this Notice for further information.

Uses and Disclosure of Health Information.

We will use and disclose your health information in order to treat you or to assist other health providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization.

Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written consent.

Uses and Disclosures Not Requiring Your Authorization.

In the following circumstances, we may disclose your health information without your written authorization: To family members who are involved in your health care; For certain limited research purposes; For purposes of public health and safety; To Government agencies for purposes of their audits, investigations and other oversight activities; To Government authorities to prevent child abuse or domestic violence; To the FDA to report product deficits or incidents; To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders; When required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient Rights

As our patient, you have the following rights:

To have access to and/or a copy of your health information; To receive an accounting of certain disclosures we have made of your health information; To request restrictions as to how your health information is used or disclosed; To request that we communicate with you in confidence; To request that we amend your health information; To receive notice of our privacy practices. If you have a question, concern or complaint regarding our privacy practices, please refer to the Notice of Privacy Practices for the person or persons whom you may contact.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

Patient's Signature:_____ Date:_____

Parent/Authorized Individual Signature if needed:_____