



**MEDICAL HISTORY QUESTIONNAIRE**

**Patient Information**

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

Gender: \_\_\_\_\_ Preferred Pronouns: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

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

Have you been a patient here before?  YES  NO

Is this a sports related injury?  YES  NO

If yes, list school and sport \_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Employer Information (Workers Compensation only)**

Company Name: \_\_\_\_\_ Work Title: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Work phone: \_\_\_\_\_

**APPOINTMENT REMINDER CONSENT**

As a courtesy to our patients, we provide appointment reminders via text or telephone. 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 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 **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.*

- o **TELEPHONE REMINDER** Bryant Orthopedic and Sports Physical Therapy may call to confirm my upcoming appointments.

My phone number is: \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**CURRENT MEDICAL HISTORY**

Primary Care Physician: \_\_\_\_\_

- Date of Injury or Onset of Symptoms(if applicable): \_\_\_\_\_
  - Type of Injury (*Please Circle One*): Work related    Auto Accident    Sports Related  
 Other \_\_\_\_\_
- Date of Surgery (if applicable): \_\_\_\_\_

**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:**

- |   |  |
|---|--|
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Pacemaker           |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Latex Allergy       |
| <input type="checkbox"/> Kidney Disease         | <input type="checkbox"/> Fractures           |
| <input type="checkbox"/> Seizures               | <input type="checkbox"/> Hepatitis A/B/C     |
| <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Chest Pain          |
| <input type="checkbox"/> Thyroid Disease        | <input type="checkbox"/> AIDS/HIV            |
| <input type="checkbox"/> Surgery                | <input type="checkbox"/> Back Trouble        |
| <input type="checkbox"/> Gastric Bypass Surgery | <input type="checkbox"/> Shortness of Breath |

\_\_\_\_\_  
 \_\_\_\_\_

**Allergies:** \_\_\_\_\_

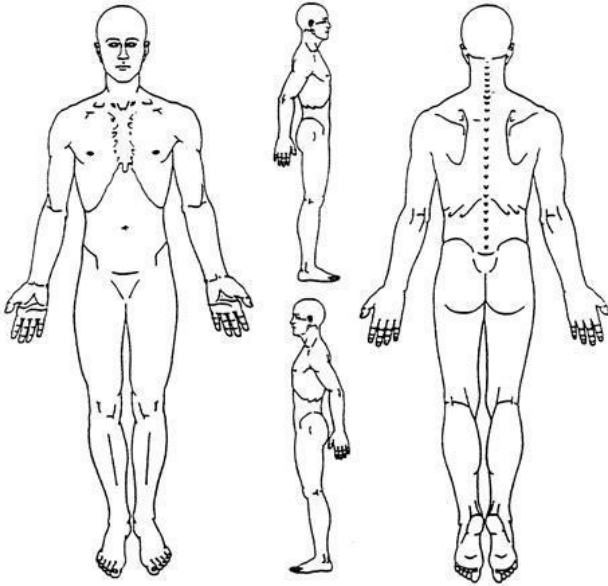
*To the best of my knowledge, all of this information of Medical History is correct.*

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

**Parent/Authorized Individual Signature if needed:** \_\_\_\_\_



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

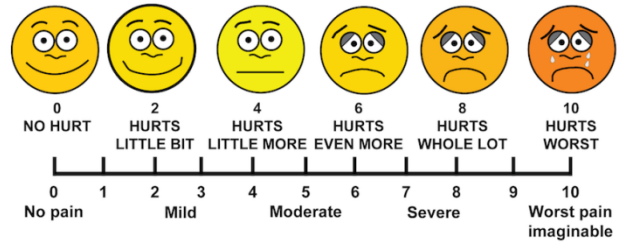


List 3 current problems for your visit today:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Please circle your pain within the past 48 hours.

**PAIN MEASUREMENT SCALE**



Pain Quality:

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

Changing degree of pain:

- Improving
- Staying the same
- Worsening

Are you awakened at night from this pain?

- Yes, how often \_\_\_\_\_
- No

I feel my best

- Morning
- Evening
- Constant pain

**Physical Limitations**

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

Dressing Tolerance

- Unable
- Increases Pain
- No Pain

Sitting Tolerance

- Unable
- Increases Pain
- No Pain

Driving Tolerance

- Unable
- Increases Pain
- No Pain

Social Life

- Unable to participate
- Increases Pain
- No Pain

**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 grace period of **15 minutes** will be permitted due to unforeseen delays that you may encounter while traveling to the clinic location for your appointment. Failure to attend your appointment within the grace period may result in rescheduling of your appointment or modification of your appointment based on your Therapist's discretion.

**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 2 sessions or more, 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:** \_\_\_\_\_

**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:** \_\_\_\_\_

**Parent/Authorized Individual Signature if needed:** \_\_\_\_\_

## 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:** \_\_\_\_\_