Welcome to All Pro Physical Therapy

1776 S. Jackson St., Suite 701, Denver, CO 80210

Patient General Information

Date _____

Name: Last _____First _____MI _____

Date of Birth: month_____date_____year_____ Social Security#:_____

Address:_____City_____State____Zip_____

Cell #:_____Home #:_____Work #:_____

Email:_____

HOW WOULD YOU LIKE TO BE REMINDED OF APPOINTMENTS? Text_____ OR Email_____

Emergency Contact:_____ Phone #:_____

Legal Guardian / Responsible Party (if under 18):_____

Referring Source (if applicable) _____

Employer:_____ Occupation:_____

POTENTIAL RISKS OF PHYSICAL THERAPY TREATMENT include but are not limited to: increased pain, tissue strain or sprain and skin irritation/burns. More remote risks include: nerve damage, heart attack, stroke and broken bones. There is also the risk of treatment failure, relapse and the need for further treatment.

POTENTIAL RISKS OF NOT **RECEIVING PHYSICAL THERAPY TREATMENT** include but are not limited to: further loss of motion/function, increased pain and other symptoms, decreased strength and arthritis.

EXPECTED BENEFITS OF PHYSICAL THERAPY TREATMENT include but are not limited to: decreased pain and other symptoms, improved functions and education for self care.

Due to the nature of "hands on" evaluation and treatment techniques used in Physical Therapy, physical contact with the injured body part and those parts related to the injury is required.

I have read the above and all of my questions have been addressed. I acknowledge that no guarantees of outcome can be given. By signing below, I authorize physical therapy evaluation and treatment.

Medical Release of Information: I authorize the release of any medical information necessary to process this claim.

Assignment of Benefits: I hereby assign payment directly to *ALL PRO PHYSICAL THERAPY,* who represents this clinic to Payor Groups. I also understand that I am financially responsible for any charges not covered by this assignment. I understand I will be held responsible for any costs incurred regarding collection of payment for services rendered.

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments.

Summary of Notice of Privacy Practice

The United States Department of Health and Human Services developed the Health Information Portability and Accountability Act (HIPAA) to maintain the privacy of your Protected Health Information (PHI) and provide you with notice of the legal rights and policies regarding the disclosure of your PHI. Our rights, as providers of Physical Therapy services to you, allow All Pro Physical Therapy, P.C. to disclose your PHI in the course of treatment, billing/ collections and normal business operations (e.g. phone calls to remind of appointments, etc). In the sharing of PHI, it is our policy to disclose only the minimum necessary amount to ensure adequate protection of your privacy. Your rights as a patient allow you to access your PHI, submit request for amendment of PHI, restrict additional access to your PHI and to make complaints regarding non-routine disclosure of PHI.

Notice of Privacy Practices Acknowledgement Form

In addition to reading the above summary, I have been offered a complete copy of the Notice of Privacy Practices for All Pro Physical Therapy, P.C. and I have been offered an opportunity to review it.

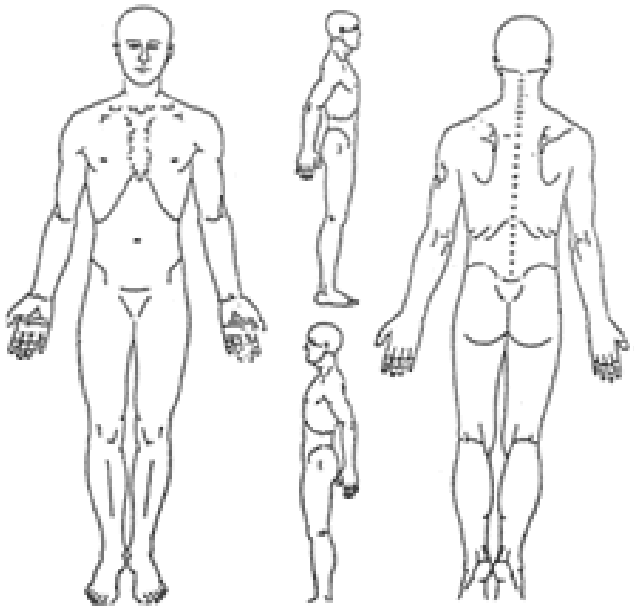
Print Name: _____Date: _____

Signature: _____

All Pro Physical Therapy, P.C.
Patient History Form

What is the main problem for which you are seeking treatment today? _____
_____
When did symptoms begin? _____
Does pain wake you at night? _____
On a scale of zero to ten (no pain to pain requiring hospitalization), please rate your pain today: _____
Have you EVER been diagnosed with any of the following?

Cancer	Yes	No
Heart Attack	Yes	No
High Blood Pressure	Yes	No
Stroke	Yes	No
Asthma	Yes	No
Emphysema	Yes	No
Chemical Dependency	Yes	No
Alcoholism	Yes	No
Thyroid Problems	Yes	No
Diabetes	Yes	No
Multiple Sclerosis	Yes	No
Rheumatoid Arthritis	Yes	N
Hepatitis A B C	Yes	No
Tuberculosis	Yes	No
Kidney Disease	Yes	No
Anemia	Yes	No
Epilepsy	Yes	No
AIDS/HIV	Yes	No
Long Term Steroid Use	Yes	No



Indicate symptoms on body chart above using the following key: X=pain, O=numbness or tingling

Do you use tobacco products? _____
Please list any medication you are currently taking: _____
_____
_____
Please list any surgeries, injuries or conditions for which you have been hospitalized or treated, including the approximate date and reason:

DATE SURGERY/HOSPITALIZATION/INJURY

_____ _____
_____ _____
_____ _____

OFFICE USE ONLY:

BP_____ HR_____ HT_____ WT_____ BMI_____ HIP/WAIST RATIO_____