



WELCOME

Welcome to RET PT Group. We are honored you have chosen us to guide you through your rehabilitation process. We understand filling out paperwork can be difficult. We have made a concerted effort to minimize the amount of paperwork required, while also making sure we have all the information we need to provide you with the highest quality of service.

PATIENT INFORMATION

Patient Name: (First) _____ (Last) _____ (M.I.) _____

Address: _____ City, State: _____ Zip Code: _____

Home #:(_____) _____ Cell #:(_____) _____ Work #:(_____) _____

Please note whether we have permission to leave a detailed message on your answering machine if we are unable to reach you in person.

Home: Yes No Cell: Yes No Work: Yes No

Social Security #: _____ Date of Birth: _____ Age: _____ Sex: M / F

Status: Single Married Divorced Other Email Address: _____

Diagnosis or Chief complaint(s): _____

Date of Injury/Onset: _____ Did you have surgery? Yes No If yes, when? _____

Referring Doctor: _____ Clinic/Hospital: _____

Patient's Employer: _____ Patient's Spouse or Parent: _____

How did you hear about us? (Please check one):

- Doctor Friend/Relative Return Patient Phone Book RET Website Internet Search
 Clinic Sign Insurance List Charity Event Seminar Newspaper Other RET Clinic
 Community Event Other: _____

In case of emergency, please contact: (List a friend or relative that can be reached during office hours)

Name: _____ Phone #: (_____) _____ Relationship: _____

CONSENT TO RECEIVE TREATMENT

By signing below, I agree to the following:

- I voluntarily give RET PT Group my consent to receive services which may include diagnostic procedures, examinations, and treatment according to the recommended plan of treatment as discussed with my therapist. I understand that physical therapy involves manual techniques that require appropriate physical contact by the health care provider and staff.

Signed: _____ **Date:** _____

(Parent/Guardian's signature if child is under 18 years old)



CANCELLATION AND BROKEN APPOINTMENT POLICY

We would like you to be aware of our cancellation and broken appointment policy. **Any appointments cancelled or broken within 24 hours of their scheduled time will be assessed a \$25 fee.**

Successful therapy is dependent on a strong working relationship between the patient and the physical therapist. Maximum progress and success are made when the patient is an active participant in their home exercise program and attends all appointments prescribed by their therapist. **It is very important to attend each appointment when it is scheduled.**

If a cancellation is unavoidable we do ask that you give us as much notice as possible so we may offer that appointment to another patient. If you arrive later than 15 minutes after the scheduled appointment time, we may ask to reschedule that appointment or may offer you a shorter treatment time based on what our schedule allows.

By signing below, you acknowledge that you have read our policy and understand your commitment to a successful physical therapy outcome. The cancellation fee is not covered by insurance and will be collected at the time of your next visit or billed directly to you as an out of pocket expense.

Signed: _____ **Date:** _____
(Parent/Guardian's signature if child is under 18 years old)

RECEIPT OF PRIVACY PRACTICES

By signing below, you acknowledge receipt of the Notice of Privacy Practices of RET PT Group. You are also authorizing RET PT Group to release your records to your insurance company and physician. Please understand your records are held in strict confidence and we will not release them to any unauthorized person. Our Notice of Privacy Practices provides further information about how we may use and disclose your protected health information. We encourage you to read it in full.

Signed: _____ **Date:** _____
(Parent/Guardian's signature if child is under 18 years old)

Please include the names of persons with whom we are allowed to discuss your condition and/or billing information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

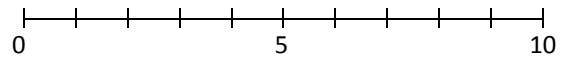
I authorize RET PT Group to discuss my medical and/or billing information with the above named person(s).

Signed: _____ **Date:** _____
(Parent/Guardian's signature if child is under 18 years old)

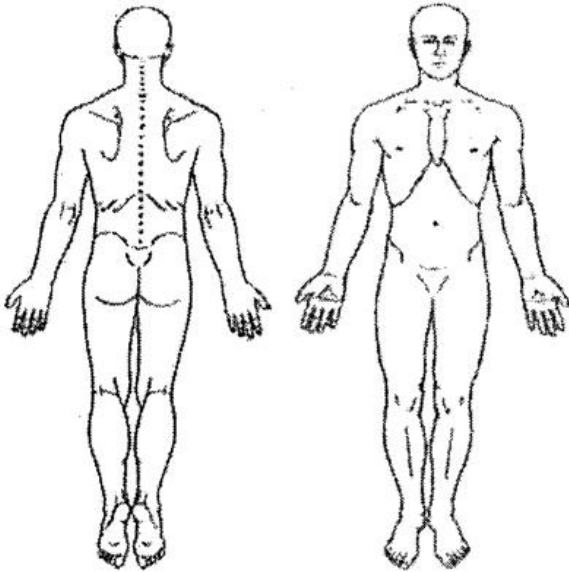
HISTORY OF PRESENT CONDITION

What are you seeing us for? _____

Please indicate the average intensity of your symptoms (0-lowest, 10-highest):



Please indicate where you have pain/symptoms:



As you go through your day, do your symptoms:

- increase decrease stay the same

Does pain ever wake you up at night?

- Yes No

What aggravates your symptoms?

- | | |
|--|--|
| <input type="checkbox"/> sitting | <input type="checkbox"/> standing |
| <input type="checkbox"/> lying down | <input type="checkbox"/> bending forward |
| <input type="checkbox"/> walking/running | <input type="checkbox"/> sleeping |
| <input type="checkbox"/> up/down stairs | <input type="checkbox"/> coughing/sneezing |
| <input type="checkbox"/> reaching overhead | <input type="checkbox"/> turning/twisting body |
| <input type="checkbox"/> lifting objects | <input type="checkbox"/> sustained movements |
| <input type="checkbox"/> playing a sport | <input type="checkbox"/> stress |
| <input type="checkbox"/> repetitive activities | <input type="checkbox"/> other _____ |

When did this issue begin? _____

Does anything relieve your symptoms? Please explain:

Describe the history of this problem (i.e. how did it occur?): _____

Have you had any previous treatment or tests for this condition? (select all that apply)

Was the onset of your symptoms gradual or sudden?

- gradual sudden

- | | |
|--|---|
| <input type="checkbox"/> physical therapy | <input type="checkbox"/> x-ray |
| <input type="checkbox"/> massage therapy | <input type="checkbox"/> MRI |
| <input type="checkbox"/> chiropractic care | <input type="checkbox"/> CT scan |
| <input type="checkbox"/> traction | <input type="checkbox"/> EMG |
| <input type="checkbox"/> bracing/taping | <input type="checkbox"/> bone scan |
| <input type="checkbox"/> hospitalization | <input type="checkbox"/> acupuncture |
| <input type="checkbox"/> bed rest | <input type="checkbox"/> casting |
| <input type="checkbox"/> exercise | <input type="checkbox"/> medication/injection |
| <input type="checkbox"/> home health care | <input type="checkbox"/> other _____ |

Overall, are your symptoms:

- improving getting worse not changing

Have you had similar symptoms in the past?

- Yes No

How would you describe your symptoms? (select all that apply)

- | | |
|--------------------------------------|------------------------------------|
| <input type="checkbox"/> sharp | <input type="checkbox"/> throbbing |
| <input type="checkbox"/> dull | <input type="checkbox"/> shooting |
| <input type="checkbox"/> numbness | <input type="checkbox"/> aching |
| <input type="checkbox"/> tingling | <input type="checkbox"/> burning |
| <input type="checkbox"/> other _____ | |

Please list any current medications, including over the counter and supplements: _____

Patient Name: _____

DOB: _____

Date: _____

