Crystal Lake
PHYSICAL THERAPY INC.

Patient Information

Date _____

Name _____ **Birth Date**_____

Address _____ **Apt #** _____

City _____ **State** _____ **Zip** _____

Day Phone _____ **Home Phone** _____

Cell Phone_____ **Would you like text reminders of appointments: Yes ☐ No☐**

Social Security Number_____ **Email** _____

Emergency Contact:_____ **Phone:**_____

Marital Status: (circle one) Married Single Other **Sex: (circle one)** Male or Female

Are You A Former Patient? Yes or No

How Did You Hear About Us? Website Insurance Location/Signage Physician Referral Other

If you answered Other, please explain _____

Have You Had Therapy Within The Calendar Year? Yes or No If Yes, where _____

Approximately how many sessions have you received within the calendar year? _____

Current Employment/School Information

Employer _____ **School** _____

Physician Information

Referring Physician _____ **Phone** _____

Address _____

If you would like us to send copies of correspondence to your primary care physician, please complete:

Primary Care Physician _____ **Phone** _____

Address _____

Auto/3rd Party Auto Information

Is this an Auto Accident? Yes or No Date of accident _____

In what city and state did the accident occur? _____

Is this a Lawsuit? Yes or No Law Firm Name _____

Attorney Name _____ **Attorney Phone** _____

Insurance Information

Primary Insurance Company _____

Name of Policy Holder _____ **Relationship** _____

Date of Birth _____ **ID #** _____ **Group #** _____

Secondary Insurance Company _____

Name of Policy Holder _____ **Relationship** _____

Date of Birth _____ **ID#** _____ **Group #** _____

Workers Compensation

Employers Name: _____ **Employers Phone #** _____

Employer Headquarters—City/State: _____

Job Title: _____

Is this an approved Worker's Comp Injury? ○ Yes or ○ No **Date of Injury** _____

In what city and state did the injury occur? _____

Case Manager:_____ **Phone#:**_____

Adjuster:_____ **Phone#:**_____

Law Firm Name _____ **Attorney Name** _____

Attorney Phone _____

MEDICAL HISTORY AND PATIENT QUESTIONNAIRE

Name _____ Age _____

What problem(s) are you being treated for today? (Describe type and location of symptoms)_____

_____

_____

What date did your present symptoms start? _____

How did your problem(s) begin? _____

My symptoms are currently ◯ GETTING BETTER ◉ GETTING WORSE ◯ STAYING THE SAME

My symptoms currently: ◯ COME AND GO ◯ ARE CONSTANT ◉ CONSTANT, BUT CHANGE WITH ACTIVITY

What makes your symptoms *better?* _____

What makes your symptoms *worse*? _____

What time of day are your symptoms worse: _____

Treatment received so far for this problem (please circle): Chiropractic Acupuncture Injections

◯ Physical/Occupational Therapy Other: _____

Indicate special tests performed for this problem and results if known (circle all that apply):

X-ray _____ Bone Scan _____ CT Scan _____ MRI _____

Other: _____

What is your goal for therapy? _____

Date of next physician appointment: _____

Medical History

Have you recently noted any of the following (check all that apply):

□Changes in bowel/bladder function

□Changes in appetite

□Difficulty maintaining balance

□Shortness of breath

□Weakness/fatigue

□Weight loss/gain

□Nausea/vomiting

□Headaches

□Numbness/tingling

□Dizziness/lightheadedness

□Fever/chills/sweats

Please list past medical history (i.e. falls, pacemakers, surgeries) include dates (indicate if current condition): _____

_____

_____

Please list any allergies (i.e. latex, adhesives): _____

Are you pregnant? ◯ **YES** ◯ **NO** **If Yes, number of weeks:** _____

Medications

Please provide names of all medications, vitamins, supplements, and over-the-counter drugs you are currently taking. We can copy a detailed list if you have one. Include The Medication Name, Dose, How Often and How It Is Taken (i.e. pill, patch, injection, inhaler)

_____

_____

_____

_____

List any medication(s) you are allergic to: _____

Social History

Home:

Please circle choice that applies: House ◯ Condo/Apt ◉ Group Residence ◯ Nursing Home ◯

Do you live alone? ◉ Yes ◯ No

Occupation:

Are you currently working? ◯ Light duty ◉ Full Duty ◉ Not Working If not working, date last worked _____

Leisure Activities/Hobbies/Exercise Routine: _____

_____

Do You Use Tobacco? ◯ **YES** ◯ **NO** **If Yes, indicate type, amount and frequency** _____

Alcohol intake and frequency: _____

Is there anything else we should know that is pertinent to your treatment? _____

_____

_____

The above information I have supplied is complete, true, and correct to the best of my knowledge.

Patient/Guardian Signature _____ **Date** _____

Consent For Treatment And Statement Of Financial Responsibility

1. **Consent For Treatment**—I consent to and authorize my physical therapist as well as other assistants/health care providers who may be involved with my care, to provide care and treatment prescribed and/or considered necessary and advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment.
2. **Attendance Policy**—I understand the importance of attending therapy consistently and for arriving to my scheduled appointment promptly. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. ***I agree to provide 24 hours notice when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment will result in a cancel/no show charge of $45.***
3. **Responsibility For Payment**—All co-payments are due at the time of service. I acknowledge that in consideration of the services provided to me by Crystal Lake Physical Therapy Inc., I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Crystal Lake Physical Therapy Inc with current insurance information and to familiarize myself with my insurance plan and its policies. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance, or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible. **There will be an additional $25.00 charge for any return checks from your bank for Insufficient Funds.**

   Please note that refusal to sign this form does not change responsibility for payment in any way.
4. **Assignment Of Benefits**—I hereby assign to Crystal Lake Physical Therapy Inc all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.
5. **Access To And Release Of Health Information**—I understand that Crystal Lake Physical Therapy Inc may document medical and other information related to my treatment in electronic and/or other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and Crystal Lake Physical Therapy Inc.'s administrative staff to contact other health care professionals that may have information related to my prior and current medical conditions and treatment. I acknowledge that I have received the Crystal Lake Physical Therapy Inc Notice Of Privacy Practices and that it outlines how my health information will be used and disclosed and how I may access and gain control of my health information.
6. **HIPPA Consents**—In compliance with HIPPA regulations, I consent to the following individuals receiving verbal information regarding the billing of my account:

_____ _____ _____

Name/Relationship Name/Relationship Name/Relationship

By my signature below, I certify that I have read, understand and fully agree to each of the statements in this document and sign below freely and voluntarily.

_____ _____

Signature of Patient or Legally Responsible Individual Date

_____

Printed name of above