



Returning Patient Update

Thank you for choosing to come back to ProTailored Physical Therapy for your physical therapy needs! You are like family to us. We become invested in who you are and how you're doing and always look forward to the opportunity to catch up and provide you with the same great care you experienced in the past!

-From the ProTailored Family-

First Name _____ MI _____ Last Name _____ Today's Date _____

Email _____

Please check this box if you do **NOT** want to receive email newsletters, updates, and condition-specific health tips

Please write down any changes in the following:

Address _____ Phone Number _____

Insurance _____

Medication _____ Other (allergies, hospitalizations, etc) _____

****Direct Access Patients Only:** *In the state of Indiana, you can receive physical therapy services for 24 days without a script from a physician. If you would like our office to work on obtaining a script on your behalf so that you may be treated beyond the 24 days, please identify a physician you'd like us to contact in order to receive a script for you:*

Please reach out to _____ (Doctor's name) to obtain a script for my PT treatment.

Primary Care Physician _____ Referring Physician _____

Seeking treatment for _____ Pain Onset/Injury Date _____

Any imaging (X-Ray/MRI) relating to the area of concern? Yes No If so, where and when? _____

Are you receiving or have you recently received home health services? Yes No

Are you receiving or have you recently received other therapy services? Yes No

If "Yes", please explain _____

Please list any new (since past visit) surgeries or other conditions for which you have been hospitalized:

Could you be, or are you, pregnant? Yes No

Please check any of the following which you have recently noticed:

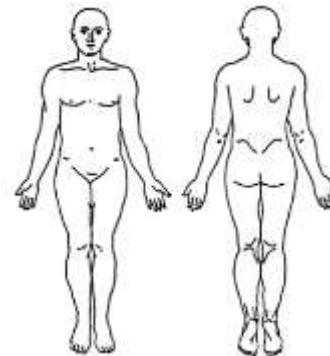
Weight loss/gain Nausea/vomiting Fatigue Weakness Fever/chills/sweats Numbness/tingling

Which of the following conditions are you currently being treated or have been treated for in the past? (please check)

- | | |
|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Other arthritic conditions | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Circulation problems |
| <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Emphysema/Bronchitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Recent weight loss/gain |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Latex Allergy |

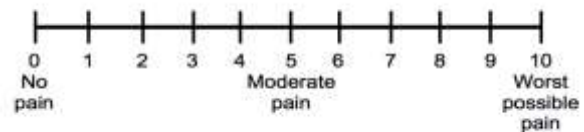
If you checked any of the above or have other conditions not listed, please explain:

Circle the parts of the body that are currently giving you discomfort:

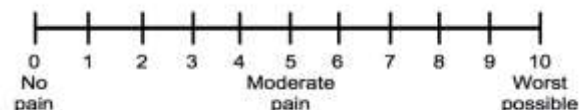


Using the scales below, indicate your pain levels by circling the appropriate number on the following scales.

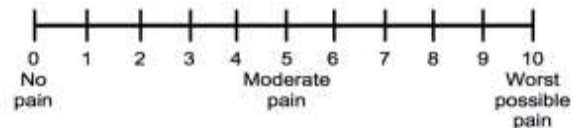
Please rate your **current** level of pain:



Please rate your **worst** level of pain in the last 24 hours:



Please rate your **best** level of pain in the last 24:





Patient Authorization

Release of Information and Consent for Treatment

All information provided herein is true and correct. I am aware of my diagnosis and wish to receive treatment at ProTailored Physical Therapy, LLC. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing, and treatment. No guarantees have been made to me about the outcome of this care. I give permission to ProTailored Physical Therapy, LLC to release information, verbal and written, contained in my medical record and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related health care provider, assignees, beneficiaries, and/or all other related persons as it relates to my treatment and/or payment for services provided. I authorize ProTailored Physical Therapy, LLC to obtain medical records and/or professional information from my physician and/or other medical professional as it relates to my treatment.

The initials below certify that I have read and understand the above information:

Initial _____

Notice of Privacy Practices (HIPPA Acknowledgement/Consent)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for ProTailored Physical Therapy, LLC. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations. I understand the risks associated with the use of email and text messaging as a form of communication between the ProTailored staff and me, as well as any other instructions that ProTailored may impose to communicate with me by email or text message. I consent to ProTailored sending me letters via email. Emails are sent through the MailChimp email service. I understand that they are sent via a public network to a personal email address and as such may not be secure. I agree to advise the practice if my email address changes.

Initial _____

Missed Appointment Policy

All appointments require a 24-hour cancellation notice to avoid a \$50 missed appointment fee.

We, along with your physician, have given time and thought to your treatment plan, but it will not work if you are not here. Your therapist is committed to your recovery and has reserved a 40 minute one-on-one block of time in their schedule for each appointment you make; we expect the same commitment from you by keeping your scheduled appointments as this can mean the difference between whether you succeed in therapy or not. Please attend your appointments on time, as tardiness not only affects your care, but the care of others. If you know you are going to be more than 10 minutes late, PLEASE CALL. You will be charged a \$50 administrative fee (which is not refunded by insurance) for not showing up to your appointment or cancelling with less than a 24 hour notice. If you do not show up to two or more of your appointments, services may be discontinued due to non-compliance.

I affirm the information above is correct, and I understand the missed appointment policy

Signature of Patient or Responsible Party

Date

I certify that I have read, understood, and filled out all the information in this packet accurately to the best of my knowledge:

Patient Name _____ Patient/Guardian Signature _____ Date _____

Witness Signature _____ Date _____

