**Hope Physical Therapy**

Confidential Health History Form

***Excellence is a continuous process and not an accident. – APJ Abdul Kalam***A body of water with a mountain in the ocean

Description automatically generated

\*Manual Therapy \* Spine and Neck\* Headaches \* Women’s Health \* Trigger Point Dry Needling\*

**Confidential Health History Forms**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please list areas of complaints/ areas of concern to you in order of importance to you:

Complaint: What brought it on? What aggravates it? What relieves it?

**1**.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2**.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3**.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did your symptoms start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been hospitalized for your primary complaint? NO \_\_\_\_\_\_\_\_ YES \_\_\_\_\_\_\_\_

Is your primary complaint interfering with your activities at home? NO \_\_\_\_\_\_ YES \_\_\_\_\_\_\_ Intermittent/ constant

Is your primary complaint interfering with your activities at work? NO \_\_\_\_\_\_ YES \_\_\_\_\_\_\_\_ intermittent/ constant

Has there been a medical diagnosis? NO \_\_\_\_\_\_\_ YES \_\_\_\_\_

\_\_\_\_\_XRAY \_\_\_\_\_MRI \_\_\_\_\_\_\_ Scan \_\_\_\_\_\_\_\_BLOODWORK\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had this problem before? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What caused the episode? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the previous diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What treatments helped? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Medical History:

List all surgical dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any infections/ illnesses:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all broken bones: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Motor Vehicles/ accidents/ falls: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I primarily sleep on my: Side (Right/ Left) Back Stomach (Circle all that apply)

I wear: Orthotics Heel lift (Right/ Left) Arch Supports Inner Soles (Circle all that apply)

Do you have any of the following: (Circle all that apply)

High blood pressure Allergies/Hay Fever Headaches Spinal Disc problems

Low Blood pressure Asthma Head feels too heavy Neuropathy

Heart Disease Cancer Shooting head pains Cold hands and/or feet

Stroke Diabetes Light Sensitivity Arthritis: OA or RA

TIA Anemia TMJ/ jaw pain Joint Pain

Thyroid Tuberculosis Chest pain Swollen joints

Kidney problems HIV/AIDS Loss of smell Arms/ hands: right/left

Liver problems Depression Dizziness/fainting - pain

Hepatitis Anxiety Vertigo - pins and needles

Gallbladder problems Memory Loss Loss of balance -numbness

Ulcers Sleep disorder Ringing in your ears Legs/feet: right/left

Nervous stomach Cold sweats Wear contacts/glasses - pain

Inner tension Fatigue - pins and needles

Intestinal problems Irritability -numbness

Constipation/ diarrhea Nervousness

Urinary problems

Pelvic pain

Pain right now:

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 😊 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | ☹ 10 |

Pain at its worst:

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 😊 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | ☹ 10 |

Pain at its best:

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 😊 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | ☹ 10 |

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**Financial Policy**

Welcome! And thank you for choosing Hope Physical Therapy as one of your health care providers. I am committed to your successful physical therapy treatment and will strive for your optimal health. The following is a statement of my financial policies which I require you to read, consent, and sign prior to your treatment. Please feel free to ask any questions regarding these policies.

* Payment is due at the time of service.
* I require 24-hour notice of cancellation. Cancelled and missed appointments within the 24 hour period may be subject to the full cost of the appointment
* You agree to reimburse me the cost of any collection agency, which may be based on a per centage at maximum 33% of the debt, plus all costs and expenses, including reasonable attorney fees I incur in such collection efforts.

I have read, understand, and agree to the provisions of this financial policy.

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

Printed Name (Parent or Legal Guardian) Date:

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

Signature (Parent or Legal Guardian)

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**Authorization to Release Protected Health Information (PHI)**

I authorize Hope Physical Therapy to discuss appointment dates, times, location, medical history, diagnosis, treatment, prognosis, financial, insurance, and billing information with those listed below. I understand that my or my child’s healthcare provider will use her judgement in sharing this information in order to foster continuity of care. The release of copies of medical records require a signed HIPPA compliant authorization. This permission will be considered on-going until I indicate otherwise in writing.

PHI may be released to the following: (please include name, relationship to patient, phone number)

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

YES \_\_\_\_\_\_ NO \_\_\_\_\_ Hope Physical Therapy has permission to share my or my child’s personal health information with family members or others in the room with me/us during the appointment.

Hope Physical Therapy has my permission to leave messages concerning treatments/appointments on my:

\_\_\_\_\_ Home voice mail/ answering machine Landline/ home phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Cell phone voice mail Cell phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Cell phone text Cell phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Work voice mail/answering machine Work phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Email (encrypted/ unencrypted) Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_ NO INFORMATION: I do not authorize the release of any verbal, text, email (other than appointment reminders to the numbers I have provided).

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

Patient Printed Name Date

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

Patient Signature

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**Consent to Treat:**  
I consent to and authorize Hope Physical Therapy to administer physical therapy treatment under the direction and supervision of the physical therapist. I understand and am informed that, as in the practice of medicine, physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform the physical therapist/staff about any health problems or allergies I have, as well as medications I am taking.

**Minor Patients:**The parent or guardian accompanying a minor is responsible for payment of services. Unaccompanied minors (under 18) will be denied non-emergency treatment, unless the parent or guardian has signed patient and financial responsibility forms. Parents should plan to remain present with their child during treatment.

**Release of Information:**Hope Physical Therapy releases patient health care information for purposes of treatment or payment, or to other health care organizations, as explained in our HIPAA Notice of Privacy Practice. I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

**No Guarantees:**  
I understand that the practice of physical therapy is not an exact science and that no guarantees have been made to me as a result of treatments or examinations by the physical therapist or supportive staff. I understand that no contract, guarantee, warranty, or promise concerning the results of the physical therapy services is made.

**Collections:**  
If your account becomes delinquent, collection proceedings will occur, and you will be 100% liable for any collection fees, attorney and court costs incurred by Hope Physical Therapy to collect said fees from the Responsible Party.

**Appointments:**   
If you arrive late for your appointment, the therapists may not have the time to treat you or your therapy time may be reduced.

The undersigned patient acknowledges that he/she has read and agrees to the information presented above.  
***NOTE:*** *If you would like to consent to these terms as a parent or guardian please complete the 'Parent/Guardian' field below.*

|  |  |  |
| --- | --- | --- |
| Client Name | Date | Parent/Guardian |

|  |
| --- |
| *I understand that by marking the 'I Accept' box that I am assenting to the terms listed above and am entering into a legally binding agreement.*  I AcceptI do not Accept |