Beyond
Therapy & Wellness

Name: ____________________________ **DOB:** ________________ **Date:** ________________
Address: ____________________________ **City:** ______________ **Zip:** ________________
Phone: ________________ ❑ **home** ❑ **mobile | Secondary Phone:** ________________ ❑ **home** ❑ **mobile**
Email address: ____
How would you like to receive appointment reminders? ❑ **Text** ❑ **Automated Call** ❑ **Email**
How did you hear about us? ____

Primary Insurance Policy Holder (if not you) Name: ________________________ **DOB:** ____________
Primary Insurance: ________________ **Secondary Ins:** ________________ **Tertiary Ins:** ________________

Age: ________ **Height:** ________ **Weight:** ________
Do you exercise regularly? If so, what type? ____
Occupation, including activities required for your job: ________________________________
____

Are you on a work restriction from your doctor? ❑ Yes ❑ No
FOR WOMEN: Are you currently pregnant or think you might be pregnant? ❑ Yes ❑ No

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What are we seeing you for today? ____
What date (roughly) did your present symptoms start? ________________________________
What do you think caused your symptoms? ____
Your symptoms are currently: ❑ **Getting Better** ❑ **Getting Worse** ❑ **Staying about the same**
Treatment received so far for this problem (chiropractic, injections, etc) ________________________
____
Please list special tests performed for this problem (x-ray, MRI, labs, etc) ______________________
____

Using the 0 to 10 the scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:

Your current level of pain while completing this survey: ________
The best your pain has been during the past week: ____________
The worst your pain has been during the past week: ___________

Have you RECENTLY noted any of the following (check all that apply)?

❑ fatigue
❑ fever/chills/sweats
❑ nausea/vomiting
❑ cough
❑ difficulty maintaining balance while walking
❑ changes in bowel or bladder function
❑ numbness or tingling
❑ muscle weakness
❑ dizziness/lightheadedness
❑ heartburn/indigestion
❑ difficulty swallowing
❑ ________________________
❑ weight loss/gain
❑ headaches
❑ shortness of breath
❑ fainting
❑ cough
❑ ________________________

Have you or a close family member EVER been diagnosed with any of the following conditions (check all that apply to you and circle those that apply to your family history)?

- ❑ cancer
- ❑ heart problems
- ❑ chest pain/angina
- ❑ asthma
- ❑ rheumatoid arthritis
- ❑ other arthritic condition
- ❑ bladder/urinary tract infection
- ❑ chemical dependency (i.e., alcoholism)
- ❑ sexually transmitted disease/HIV
- ❑ depression
- ❑ lung problems
- ❑ osteoporosis
- ❑ multiple sclerosis
- ❑ epilepsy
- ❑ stroke
- ❑ anemia
- ❑ bone or joint infection
- ❑ pelvic inflammatory disease
- ❑ thyroid problems
- ❑ diabetes
- ❑ high blood pressure
- ❑ circulation problems
- ❑ blood clots
- ❑ ulcers
- ❑ kidney problem/infection
- ❑ hepatitis
- ❑ liver problems

ALLERGIES: Skin (latex) or medication(s): ____

____

Please list any surgeries, and or medical conditions for which you have been hospitalized, including dates:

1. ______________________________ 2. ______________________________ 3. ______________________________
2. ______________________________ 3. ______________________________ 4. ______________________________
5. ______________________________ 6. ______________________________ 7. ______________________________

Emergency Contact Information:
Name of contact: ___________________________ Relationship: _______________________________
Primary Phone #: ___________________________Work Phone #: ______________________________

Patient Signature: ____ Date: _________________________

Therapist Notes:

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Patient Consent

Please initial next to each patient consent statement.

_____ I hereby consent to physical therapy treatment as prescribed by my physician, or as deemed necessary by the treating physical therapist. I also understand that physical therapy treatment, by its nature, involves inherent and unavoidable risks, including falls, and other similar injuries, and that the only alternative to entirely avoid these risks would be to forego physical therapy all together.

______ I understand I am responsible for charges incurred, regardless of insurance coverage. If Beyond Therapy & Wellness has a contract with your insurance carrier, we will file the claim. If the insurance company denies payment for no referral, non-covered services, deductible, etc, I am responsible for all balances due.

______ I assign all benefits to Beyond Therapy & Wellness PLLC that are received from my insurance provider for physical therapy services rendered.

______ It is advised that a parent or guardian attend all sessions with patients that are **minors** and I waive any claim that I may have due to my failure to comply with this advisement.

_____ I understand that Beyond Therapy & Wellness PLLC takes all actions available to keep my personal information private. I have received the Notice of Privacy Practices from Beyond Therapy & Wellness PLLC.

Cancellation Policy:

To reach your goals it is necessary for you to attend your scheduled treatment sessions. This ensures we can provide effective treatment to you and others.

If you cancel with less than 24 hours' notice it impacts 3 individuals:

1) **Yourself** – You limit your ability to reach your goals
2) **Your Therapist** –Time has been made in the therapists schedule specifically for you
3) **Another patient** – Your appointment time is not given to others that are waiting to begin PT when cancellations occur last minute.

Please call our office to cancel. Text message cancellations do not arrive within the 24 hour time window and you will get charged the $40.00 cancellation fee.

______ I understand a cancellation fee of **$40.00** will be charged to me for each appointment that is cancelled with less than 24 hours' notice.

______ I understand that text message cancellations arrive with less than a 24 hour notice and I will get charged the cancellation fee if I cancel through text.

We are happy to work with your schedule and the fee is waived when you reschedule your appointment in the same calendar week.

I certify that all information provided to Beyond Therapy & Wellness, PLLC is correct.

____ ______________________

Patient/Legal Guardian Signature Date