



**PATIENT INFORMATION** Social Security #: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ Sex: M F

Pt. Name: First: \_\_\_\_\_ Last: \_\_\_\_\_ MI \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Marital Status: M D S W Emp: PT FT R U

EMERGENCY CONTACT \_\_\_\_\_ PHONE # \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

**THE FOLLOWING PEOPLE MAY HAVE ACCESS TO MY MEDICAL INFORMATION**

SPOUSE \_\_\_\_\_ Parent \_\_\_\_\_ CHILD \_\_\_\_\_

OTHER \_\_\_\_\_  NOBODY SHOULD HAVE ACCESS

**CONSENT FOR TREATMENT AND AUTHORIZATION**

I \_\_\_\_\_ (the patient/guardian/legal representative to the patient acting on the patient's behalf) authorize McCombs & Associates Physical Therapy and its staff to perform the physical therapy treatments ordered by my physician. I request that payment of any insurance or other benefits be made directly to McCombs & Associates Physical Therapy on my behalf for any services provided to me. I authorize the holder of medical and other information about me to release to Medicare and its agents, any insurance company, any third party payer, state medical assistance agency, or any other government private payer responsible for paying such benefits, any information needed to determine these benefits for related services. I agree to pay for all charges not covered by an insurance company and or secondary and or tertiary insurance companies.

I understand that any deductibles, co-payment/co-insurance is due and payable at time of service Initial Here \_\_\_\_\_  
I understand there will be a \$10 collection fee for any account turned over to a collection agency.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I hereby acknowledgement that I have received a copy of the Notice of Privacy Practices and understand that McCombs & Associates Physical Therapy has the right to change the Notice of Privacy Practices from time to time and that I may contact McCombs & Associates Physical Therapy at any time to obtain a current copy of the Notice of Privacy Practice. Initial Here \_\_\_\_\_

**Cancellation Policy**

Please give us a **24 hour** notice of canceling your appointment so that we may fill your appointment time.

**First time** canceling/no show there will be a \$5 charge due on the next appointment.

**Second time** canceling/no show there will be a \$10 charge due on the next appointment.

**Third time** canceling/no show there will be a \$25 charge due on the next appointment.

Initial Here \_\_\_\_\_

*For Worker's Compensation patients, documentation of missed appointments is forwarded to your case manager and primary physician. Repeated missed appointments could jeopardize your claim.*

SIGNATURE OF PATIENT/GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_



**Patient Information Record**

1. Name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_
2. Date of onset of symptoms: \_\_\_\_\_
3. Have you had surgery for this condition? Yes / No Date of Surgery: \_\_\_\_\_
4. What caused your symptoms? \_\_\_\_\_
5. What is your biggest complaint? \_\_\_\_\_
6. What activities could you do before, that you cannot do now due to your condition? \_\_\_\_\_
7. Which activities make your symptoms worse? \_\_\_\_\_
8. Which activities make your symptoms better? \_\_\_\_\_
9. Overall, is your condition becoming worse, better, or staying the same? \_\_\_\_\_
10. Have you had similar episodes before? Yes / No If yes, when? \_\_\_\_\_
11. What other health care practitioners have you seen for this condition? \_\_\_\_\_
12. What diagnostic tests have you had for this condition (x-rays, MRI, nerve study, etc)? \_\_\_\_\_
13. What is your goal for physical therapy? \_\_\_\_\_
14. How did you hear about our clinic? \_\_\_\_\_

**Medical History**

1. What medications are you currently taking? \_\_\_\_\_

2. What allergies do you have? \_\_\_\_\_

Do you have (or have you had) any of the following health conditions?

Osteoarthritis	Yes No	High Blood Pressure	Yes No
Rheumatoid Arthritis	Yes No	Heart Disease	Yes No
Back/Neck Pain	Yes No	Poor Circulation	Yes No
Osteoporosis	Yes No	Chest Pain	Yes No
Broken Bones	Yes No	Shortness of Breath	Yes No
Sleeping Difficulties	Yes No	Vision Difficulties	Yes No
Cancer	Yes No	Dizziness/Loss of Balance	Yes No
Diabetes	Yes No	Severe/Frequent Headaches	Yes No
Weakness	Yes No	Pain at Night	Yes No
Weight Gain/Loss	Yes No	Stroke/TIA	Yes No
Asthma	Yes No	Numbness/Tingling	Yes No
Bronchitis	Yes No	Bowel/Bladder Problems	Yes No
Seizures	Yes No	Loss of Appetite	Yes No
Depression/Anxiety	Yes No	Are you pregnant?	Yes No
Do you have a pacemaker?	Yes No	Do you smoke?	Yes No

3. What other health conditions do you have? \_\_\_\_\_

4. What surgeries have you had? \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date

Clinician Signature: \_\_\_\_\_

Date

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

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

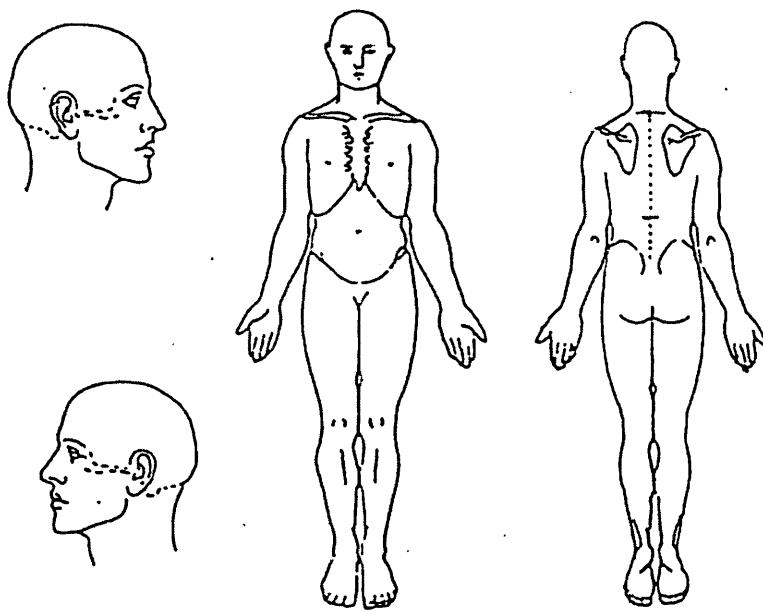
Please list 3 activities that you have the most difficulty performing because of your injury/condition. Please rate your level of difficulty on the scale below each question.

1. \_\_\_\_\_  
 0 1 2 3 4 5 6 7 8 9 10  
 No Difficulty Unable to Perform

2. \_\_\_\_\_  
 0 1 2 3 4 5 6 7 8 9 10  
 No Difficulty Unable to Perform

3. \_\_\_\_\_  
 0 1 2 3 4 5 6 7 8 9 10  
 No Difficulty Unable to Perform

Please mark on this diagram where you are having most of your pain or other symptoms



How bad is your pain most of the time? Please indicate on the scale below:

\_\_\_\_\_

0 1 2 3 4 5 6 7 8 9 10  
 No Pain Worst Pain