McCombs & Associates
Physical Therapy

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**_____

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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. 3. What other health conditions do you have? _____

_____

4. What surgeries have you had? _____

_____

Patient Signature: _____ Date

Clinician Signature: _____ Date

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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

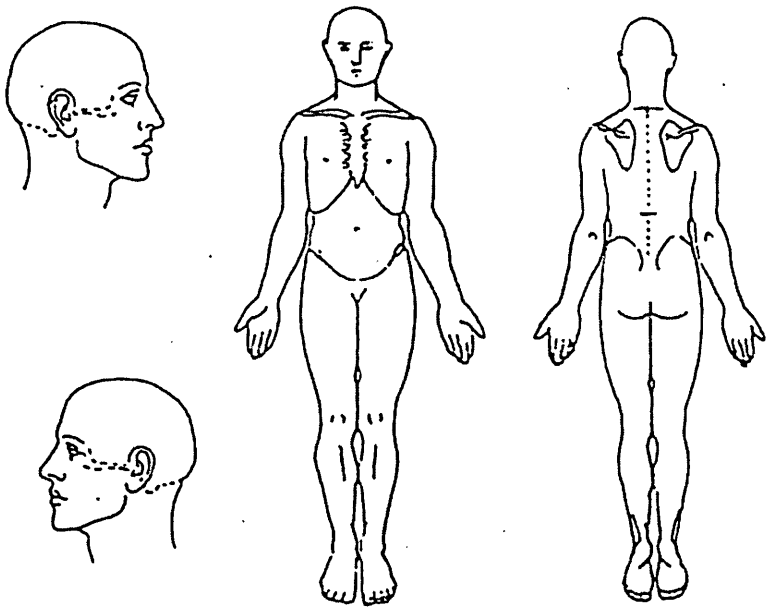
No Difficulty **Unable to Perform**

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**