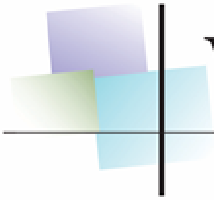

VILLAGE PHYSICAL THERAPY

Michele Childs, PT

PATIENT NAME:________________________________ SOCIAL SECURITY NUMBER:____________________

ADDRESS: _____________________________________ CITY:__________________________ ZIP:________

HOME PHONE:(   )______________ CELL PHONE:(   )________________ WK PHONE:(   )____________

BIRTHDATE: _____________________ AGE:________ SEX: M_____ F_____ MARITAL STATUS:__________

EMPLOYER: ___________________________________ ADDRESS: ___________________________________

E-MAIL ADDRESS: ____

SPOUSE (OR PARENT) NAME: __________________________________ SOCIAL SEC. #:__________________

SPOUSE/PARENT ADDRESS:_____________________________ CITY:____________________ ZIP:________

EMERGENCY CONTACT NAME: ___________________________________PHONE: (   ) __________________

We have permission to contact you at: **___home ___cell ___work ___email**
We have permission to leave a message at **___home ___cell ___work ___email**

Our **NOTICE OF PRIVACY PRACTICES** requires that we will keep your records safe.

☐ Check if you **DO NOT** wish to receive a copy of the NOTICE OF PRIVACY PRACTICES

Or ☐ Check if you WISH to receive a copy of the NOTICE OF PRIVACY PRACTICES

Patient Name:____

My Signature:____ Date:_______________

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form.

Relationship to Patient:______________ Printed Name:_______________________________________

Source of authority if not a parent: ____

FOR OFFICE USE ONLY

We attempted to obtain acknowledgment of receipt, but could not because:

( ) Individual refused to sign ( ) Communication/language barrier ( ) Emergency situation ( ) Other:

Village Physical Therapy locations:

5825 Delmonico Dr, Suite 300 **Colorado Springs**, CO 80919 **Phone: 719.577.4104**
1721 Hwy 50 W, Suite 210 **Pueblo**, CO 81008 **Fax: 719.575.0872**
801 S Perry Street, Suite 105 **Castle Rock**, CO 80104

VILLAGE PHYSICAL THERAPY
Michele Childs, PT

MEDICAL HISTORY RECORD

Name: ____ **Date**:_____________

Primary Care Physician: ______________________________ **Phone**__________________

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

bowel or bladder function	weight loss	fever/chills/sweats
nausua/vomiting	shortness of breath	pain at night
dizziness/lightheadedness/fainting	headaches	weakness/fatigue
changes in appetite	difficulty swallowing	stomach problems
skin rash	tightness of chest pain	pain/swollen joints
difficulty maintaining balance		

Have you EVER been diagnosed with any of the following conditions (circle all that apply)?

cancer(type)_______________	arthritis/gout	diabetes
heart disease/heart problems	multiple sclerosis	stroke
pacemaker	kidney/bladder problems	asthma
traumatic brain injury/head	thyroid problems	epilepsy
injury depression/mental trouble	chemical dependency	anemia
osteoporosis	growths/tumors	blood clots
Parkinsons disease	stomach ulcers	seizures
high blood pressure	back problems	ear problems
lung disease/pnuemonia	Other_________________	

FOR WOMEN: Are you currently pregnant or think you might be pregnant? **YES NO**
Do you smoke? **YES NO** ______ pack/day

Current Medications Medication Dosage/day

Medication	Dosage/day
_____________________________	________________
_____________________________	________________
_____________________________	________________
_____________________________	________________
_____________________________	________________
_____________________________	________________
_____________________________	________________

Are you currently taking blood thinning or anticoagulant medications for any medical conditions? **YES NO**

ALLERGIES: ____ **Are you latex sensitive? YES NO**

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

	Date
_____________________________	________________
_____________________________	________________
_____________________________	________________
_____________________________	________________

X____ ________________
Patient Signature **Date**

VILLAGE PHYSICAL THERAPY

Michele Childs, PT

Patient Agreement

Dear Patient,

Thank your for choosing Village Physical Therapy for your healthcare needs. Our providers and staff are dedicated to providing you the best care and customer service possible. Please take a few moments to read and sign the following patient agreement.

PATIENT AGREEMENT:

_______________________________ (your name, herein called "patient") has entered into an agreement with Village Physical Therapy (herein called "VPT")

- I promise to conduct myself in an orderly manner while at VPT (no swearing, angry outbursts, rudeness, etc. to VPT staff or other patients) or I may be discharged from the practice
- I promise to call VPT at least 24 hours prior to my appointment to cancel or reschedule, so another patient can be treated in my time slot
- I understand if I "No Show" for an appointment, I may be charged a *$40 no call/no show fee*. I understand *this WILL BE PAID BY ME* personally and will not be billed to my insurance company. If two or more appointments are missed without notice, I may be discharged from the practice.
- I hereby consent to such treatment and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while I am a patient of VPT.
- I hereby understand that VPT is not responsible for any valuables and personal property brought to the facility.
- I hereby authorize the release of any information by telephone or in writing, including reports of diagnosis, treatment prognosis, recommendations, benefits payable, as well as other data pertinent to my treatment by VPT to the physician who referred me for therapy as well as any organization responsible for payment of my account.
- I hereby authorize that the payment of authorized benefits be made directly to VPT for any services that are reimbursable by Medicare, Insurance or any third party.

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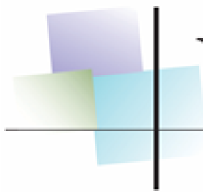

- I understand that I, the patient, am responsible for full payment of any and all services rendered by VPT to me and my family members, including all services and fees not covered by insurance. VPT bills my private insurance as a courtesy and I, as the subscriber, am responsible for understanding the terms of my policy. In the event of non-payment, I agree to pay all reasonable attorney fees and court costs if VPT refers my account to a third party collection agency.
- I understand that I am a participant in my own healthcare, and I am responsible for following my providers' healthcare plan for my own benefit.
- I understand that as long as I participate and uphold my end of this agreement, I am always welcome at VPT.

Date _____________

____
Patient Name (print)

____
Patient/Guardian Signature

ANY CHANGES OR ADDITIONS TO THIS AGREEMENT ARE NOT PERMITTED

VILLAGE PHYSICAL THERAPY

Name: ______________________ Date: ______________________

CHECK IF YOU HAVE DIFFICULTIY OR PAIN ASSOCIATED WITH ANY OF THESE ITEMS:

Self Care

Hygiene
- ☐ Grooming
- ☐ Caring for Skin
- ☐ Caring for Teeth
- ☐ Caring for Hair
- ☐ Caring for Nails (Toe & Finger)
- ☐ ______________________

Dressing
- ☐ Putting on Clothes
- ☐ Putting on Footwear
- ☐ ______________________

Bathing
- ☐ Showering
- ☐ Bathing
- ☐ ______________________

Sleep
- ☐ Disturbed Sleep
- ☐ ______________________

Daily Activities
- ☐ Shopping
- ☐ Food Preparation
- ☐ Housekeeping
- ☐ Laundry
- ☐ ______________________

Household Chores
- ☐ Vacuum
- ☐ Mop
- ☐ Dust
- ☐ ______________________

- ☐ **Driving**
- ☐ ______________________

Mobility: Walking & Moving Around

Use of an Assistive Device
- ☐ Cane
- ☐ Walker
- ☐ ______________________

Moving Around in Different Locations
- ☐ Walking Between Rooms
- ☐ Stairs
- ☐ In Home
- ☐ Public Transportation
- ☐ Walking Down the Street
- ☐ ______________________

Changing & Maintaining Body Position

Maintaining a Body Position
- ☐ Remaining Seated
- ☐ Remaining Standing
- ☐ Squatting
- ☐ Kneeling
- ☐ ______________________

Transfers
- ☐ Sliding Along a Bench
- ☐ Sit to Stand
- ☐ Rolling in Bed
- ☐ ______________________

Carrying, Moving & Handling Objects

Hand & Arm Use
- ☐ Pulling Objects
- ☐ Pushing Objects
- ☐ Reaching
- ☐ Turning Hands or Arms
- ☐ Throwing
- ☐ Catching
- ☐ ______________________

Fine Hand Use
- ☐ Picking Up
- ☐ Grasping
- ☐ Manipulating
- ☐ Releasing
- ☐ ______________________

Moving Objects with Lower Extremities
- ☐ Pushing with Lower Extremities
- ☐ ______________________

Work/Vocation/Occupation

____

____

Recreation
- ☐ Sports
- ☐ ______________________

If pain is associated with any of these activities, within how many minutes does it start?

Sit	_______	**Drive**	_______
Stand	_______	**Stairs**	_______
Walk	_______	**Job Duties**	_______
Sleep	_______	**Lifting**	_______
Use of Arms:		**Carrying**	_______
< 90 deg.	_______		
> 90 deg.	_______		

Pain is better with:
- ☐ Bending
- ☐ Sitting
- ☐ Turning
- ☐ Rising
- ☐ Standing
- ☐ Walking
- ☐ Lying
- ☐ AM
- ☐ As day progresses
- ☐ PM
- ☐ When still
- ☐ On the move

Comments:

____

____

____