



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
 1721 Hwy 50 W, Suite 210
 801 S Perry Street, Suite 105

Colorado Springs, CO 80919
Pueblo, CO 81008
Castle Rock, CO 80104

Phone: 719.577.4104
Fax: 719.575.0872

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 |
| nausea/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 injury | thyroid problems | epilepsy |
| 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/pneumonia | 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 |
|---------------------|------------|------------|
| | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |

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

Patient Agreement

Dear Patient,

Thank you 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 _____ 20____

Patient Name (print)

Patient/Guardian Signature

ANY CHANGES OR ADDITIONS TO THIS AGREEMENT ARE NOT PERMITTED

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Name: _____ Date: _____

CHECK IF YOU HAVE DIFFICULTY 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
- _____

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. _____ | |

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
- _____

Pain is better with:

- Bending
- Sitting
- Turning
- Rising
- Standing
- Walking
- Lying
- AM
- As day progresses
- PM
- When still
- On the move

Comments:

