



Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: _____ Social Security # _____

Home Phone #: _____ Work Phone #: _____ Cell #: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Emergency Contact: _____ Phone # _____ Relationship _____

Primary Care Physician / Family Doctor(s) _____

Are you currently under the care of a Home Health Agency? ___ No ___ Yes, name of Co. _____

How did you hear about Fyzical™? _____

Insurance Information

Medicare # _____ Part B effective date _____

Insurance Policy # _____ Group #: _____

Policyholder's Name: _____ Relation to Patient: _____ DOB: _____

Insurance Address (if other than above): _____

If Patient is a minor

Responsible party for bill if other than patient: _____ Relationship: _____

Responsible party's address (if other than above): _____

Date of Birth: _____ Social Security # _____

Consent for Treatment:

I hereby consent to receive care for therapy services by Fyzical™. I consent to medical treatment as is deemed necessary or advisable by the physical therapist.

Consent to Release Medical Information:

I authorize Fyzical™ to release any information acquired in connection with my therapy services including, but not limited to, diagnosis, clinical records, to myself, my insurance(s), physician(s), and _____

Consent to Obtain Medical Information:

I authorize Fyzical™ to obtain and acquire any information that would be beneficial in connection with my therapy service, which may include X-rays, Cat scans, and MRI reports, along with Physician's Documentation.

Assignment of Insurance Benefits:

I hereby authorize payment to be made directly to Fyzical™.

Guarantee of Payment:

I agree to pay any charges that my insurance does not pay. I am responsible to pay any un-covered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees, legal fees, and collection agency fees.

I hereby certify that I understand these rights as set forth.

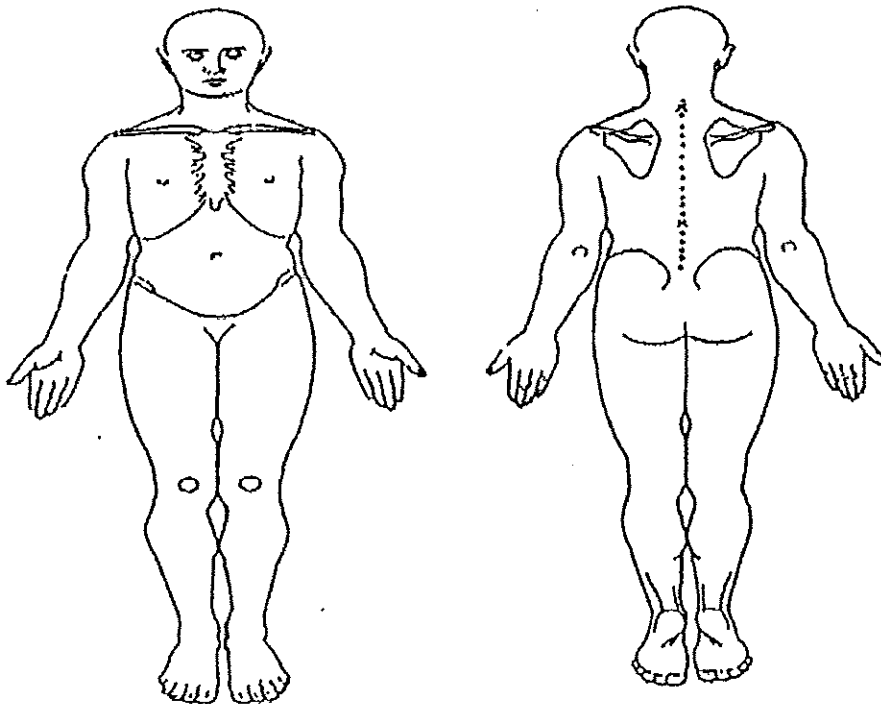
Patient/Responsible Party Signature _____ Date: _____

Fyzical Medical Intake Form

NAME _____ DATE _____

PRESENT CONDITION: PAIN / TENSION

Please place an "X" in the area or areas where you are experiencing pain/symptoms.



Please circle the words that best describe your pain.

SEVERE DULL STABBING MODERATE
BURNING NUMBNESS / TINGLING THROBBING WEAKNESS
SHARP RADIATING

Please rate your pain from 0 (no pain) to 10 (worst imaginable pain) at

Worst	0 1 2 3 4 5 6 7 8 9 10
Now	0 1 2 3 4 5 6 7 8 9 10
Best	0 1 2 3 4 5 6 7 8 9 10

Date of injury onset _____

What initially caused your pain? _____

Since it has started, has the pain changed? Yes _____ No _____

Have your symptoms become Worse _____ Better _____ The Same _____

How often do you experience the pain? _____

What makes your symptoms worse?

Sitting _____ Standing _____ Lifting _____ Bending _____

How much does your pain/problem interfere with your Daily Activities?

None 20% 40% 60% 80% 100% of the day.

Have you had any diagnostic tests related to this problem? (I.e., MRI or X-Rays)

Please Specify Where and When _____

Have you had any Physical Therapy in the past 12 months for this or any other problem?

Yes _____ No _____

If Yes, Where?

_____ When? _____

Have you had a related surgery? Yes _____ No _____

If yes, what was the date? _____

PAST MEDICAL HISTORY

Do you have, or have you had, any of the following?

- Anemia
- Asthma
- Back Pain
- Cancer
- Depression
- Disc Problems
- Dizziness / Fainting
- Excessive Fatigue
- Heart Attack
- High Blood Pressure
- Infectious Disease
- Kidney Problems
- Low Blood Pressure
- Metal Implants
- Neck Pain
- Open Wounds
- Osteoporosis
- Perforated Ear Drums
- Rheumatoid Arthritis
- Seizures
- Skin Rashes
- Stroke
- Tingling In Arms / Hands
- Typhoid/cholera/dysentery
- Seizures
- Other Health Issues (please explain)
- Allergies
- Balance
- Bowel / Bladder Issues (Incontinence)
- Chest Pains
- Diabetes
- Headaches
- Epilepsy
- Fever, Higher than 100 Degrees F
- Heart Disease
- Hypoglycemia
- Knee Pain
- Liver / Gallbladder Problems
- Low Exercise Level
- Nausea / Vomiting
- Neck Stiffness
- Osteoarthritis
- Pacemaker or Defibrillator
- Radiation Treatment within the last 3 months
- Ringing In Ears
- Shortness Of Breath/Difficulty Breathing
- Stomach or Intestinal Issues
- Thyroid Problems
- Tingling In Legs / Feet
- Vision Problems

Are you taking any medication? Yes _____ No _____

If yes, please list medications _____

Referring Physician

Physician's Name: _____ Tel # _____

Address: _____

Address

City

ST

ZC

WORK

Are you currently working? Yes _____ No _____

If yes, how many hours a week? _____

What is your occupation? _____

Please describe what you do at your job _____

Patlent's Signature _____ Date _____



Neville Flowers, M.S., PT
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INFORMED CONSENT FOR PHYSICAL THERAPY

Dear Patient,

Physical Therapy involves the use of many different types of physical evaluation and treatment. At Neville A. Flowers P.T. P.C., we use a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

Since the physical responses to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

I acknowledge that my treatment program has been explained by Neville A. Flowers P.T. P.C., and all of my questions have been answered to my satisfaction. I understand the risks associated with a program of Physical Therapy as outlined to me, and I wish to proceed.

Patient Name

Patient Signature

Date