Ellen de Neef PT, OCS

ARCUS
Physical Therapy

1 2 3 4 5

405 Kains Avenue
Suite 202
Albany, CA 94706
T 510-913-0969
info@arcus-pt.com
www.arcus-pt.com

PATIENT INFORMATION

First Name | M.I. | Last Name | Date of Birth | Sex

Home Address | City | State | Zip

Phone home | Phone work | Phone mobile | Preferred Phone number | Email

REFERRING PHYSICIAN INFORMATION

First Name | M.I. | Last Name

Office Address | City | State | Zip

Phone Office | Fax# | Email

EMERGENCY CONTACT OR LEGAL GUARDIAN INFOMATION

First Name | M.I. | Last Name

Relationship
- ☐ Emergency Contact
- ☐ Parent
- ☐ Guardian

Address | City | State | Zip

Phone home | Phone work | Phone mobile | Email Parent or Guardian

Reason visit

FINANCIAL AGREEMENT

YOU ARE FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED. PAYMENT IS TO BE MADE IN FULL AT THE TIME OF THE VISIT. IF REQUESTED BY YOU, WE WILL PROVIDE YOU WITH A RECEIPT OF PHYSICAL THERAPY SERVICES THAT YOU CAN SUBMIT TO YOUR INSURANCE COMPANY TO REQUEST FOR REIMBURSEMENT.

24 HOURS CANCELLETION POLICY

YOU WILL BE CHARGED FOR MISSED APPOINTMENTS AND CANCELLATIONS WITH LESS THAN 24 HOURS NOTICE.

I HAVE READ AND AGREE TO THE ABOVE

Signature Patient | **Date**

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Activities/Sports/Hobbies

Have you or any immediate family members been told that you/they have:

	SELF	FAMILY
Angina/Chest Pain	☐ Yes ☐ No	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No
Gastro Intestinal Disorder	☐ Yes ☐ No	☐ Yes ☐ No
Heart Disease/Heart Attack	☐ Yes ☐ No	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	☐ Yes ☐ No

Do you have a history of:

- Allergies/Asthma ☐ Yes ☐ No
- Breathing Problems ☐ Yes ☐ No
- Joint replacement/Implants ☐ Yes ☐ No
- Headaches ☐ Yes ☐ No
- Kidney & Bladder Disease ☐ Yes ☐ No
- Ulcers ☐ Yes ☐ No
- Seizures ☐ Yes ☐ No

Did you have surgery? ☐ Yes ☐ No

Have you been in a motor vehicle or other accident? ☐ Yes ☐ No

Did you have any imaging done?

- X-Ray ☐ Yes ☐ No
- MRI ☐ Yes ☐ No
- Other ☐ Yes ☐ No

Are you:

- Pregnant ☐ Yes ☐ No
- Depressed ☐ Yes ☐ No
- Under Stress ☐ Yes ☐ No

Have you had or do you experience:

- Recent Change in Health ☐ Yes ☐ No
- Fever/Chills ☐ Yes ☐ No
- Dizziness or Falls ☐ Yes ☐ No
- Nausea/Vomiting ☐ Yes ☐ No
- Unexplained Weight Loss ☐ Yes ☐ No
- Changes in Bowel or Bladder Function ☐ Yes ☐ No
- Hearing Problems ☐ Yes ☐ No
- Visual Disturbances ☐ Yes ☐ No

How well do you sleep at night:

- Fine ☐
- Moderate Difficulty ☐
- Only With Medication ☐

Are your symptoms:

- Getting Worse ☐
- Remaining the Same ☐
- Improving ☐

Date of Last Physical Examination

List of Medications & Dosages

Do you have any other health problems, not mentioned above or anything else you would like to share?

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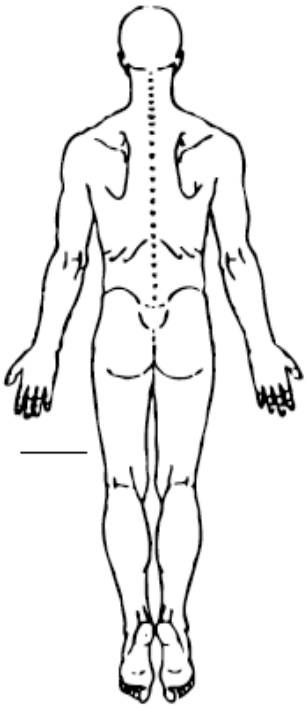
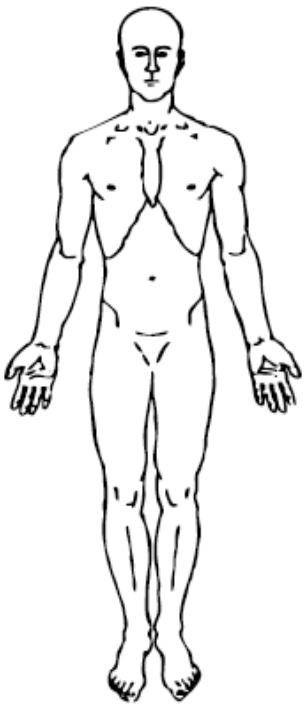
Patient _____

Weight _____ **Lbs** **Height** _____ **Ft/Inch**



Indicate the areas where you experience pain /symptoms.
Please use the symbols to describe your pain /symptoms

XXX Pain
///// Stiffness
..... Tingling
ooo Numbness



Please indicate the severity of pain & discomfort, with 0 : no pain and 10 the most severe

When you're feeling at best	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
When you're feeling at worst	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
How you're feeling now	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10

Other complaints

What are your goals for Physical Therapy?

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CONDITIONS & CONSENT FOR PHYSICAL THERAPY

Informed Consent for Treatment:
The term “informed consent” means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Potential benefits may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Potential risks:
I understand I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

No warranty:
I understand that my physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Alternatives:
If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.
I have read the above information and I consent to physical therapy evaluation and treatment.
By initialing above and signing below, I acknowledge that I have read, understood and will abide by the conditions and policies noted on this consent form.

Patient

Therapist

Signature Patient

Date

Signature Therapist

Date

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PATIENT INFORMATION CONSENT FORM

Privacy Practices
The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Legal Duty
The law requires us to: 1) Keep your medical information private. 2) Give you notice describing our legal duties and privacy practices. 3) Notify you of any changes in our privacy practices.

Use and Disclosure
The following paragraphs describe different ways that we are permitted to use and disclose medical information. We will not use or disclose any medical information not listed without specific written authorization from you.

Treatment:
We may use medical information about you to provide you with medical treatment or other services related to your care. We may disclose medical information about you to doctors, nurses, technicians or other people involved in your care. We may also share medical information about you to your other health care providers to assist them in treating you. We may disclose your personal health information in case of emergencies and when required by law. I may use your information to provide appointment reminders and communicate information to you.

Payment:
We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third party payer (i.e., insurance company, attorney, consulting physician). We may also disclose information to your health plan about treatment or possible treatment to help determine if your health plan will pay for certain services.

If you have any question about any of our policies or your rights, please feel free to ask me.

Your signature below indicates your understanding and compliance of the above privacy practices.

Patient

Signature Patient

Date