RISE
PHYSICAL THERAPY & PILATES

New Patient Information

Name:_____

DOB:_____/_____/_____

Address:_____

_____

City:_____

State:_____ **Zip**:_____

Phone #:_____

Email:_____

Diagnosis: _____

_____

_____

Primary Insurance:_____

Insured:_____

ID #: _____

GRP #:_____

Secondary Insurance:_____

Insured:_____

ID #: _____

Group #:_____

#1 Emergency Contact:

Name:_____

Phone: _____

Relation:_____

First Appointment: _____

(For Office Only)

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Patient History Form

Patient Name:_____ Diagnosis:_____

Have you ever had any of the following (mark all that apply):

	YES	NO		YES	NO
Allergies			Diabetes		
Allergies to Medication			High Blood Pressure		
Stroke/TIA			Orthopedic Problems		
Cardiac Event			Neurological Diagnosis		
Chest Pain			Surgery		
Light headedness or fainting			Hospitalization		
Headaches			Are you Pregnant		
Migraines			Pacemaker or DBS		
Epilepsy			Peripheral Vascular Disease		
Pulmonary Disease			Phlebitis/Emboli		

Please explain any “yes” answers:_____
_____
_____
_____

Please describe surgical history:_____
_____
_____

Previous Physical Therapy:_____
_____
_____

Do you exercise & if so, how many times per week?_____

Do you smoke or have you smoked in the past? Yes No If yes, how many packs/day:_____ Year Quit:_____

Do you drink alcoholic beverages? Yes No If yes, how many drinks per week:_____

Do you drink beverages containing caffeine? Yes No If yes, how many drinks per week:_____

Job:_____ Hours/Day:_____

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Hobbies or recreational activities:_____

Any other pertinent information:_____

Physician:_____ Physician phone number:_____

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Medication List

We need a complete and accurate list of your current medications including prescription, over the counter and any vitamins or herbal supplements you are taking. This information helps us to keep you safe during your treatments and is necessary in case of emergency.

Medication	Dose	Quantity	Frequency	Last Taken	Comments

I certify that this information is complete and accurate. I will let my provider know if there are any changes to these medications or if any new medications are added.

Patient Signature:_____ Date:_____

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Informed Consent to Treat

Physical therapy involves the use of many different types of physical evaluation and treatment. At Rise Physical Therapy and Pilates we use a variety of procedures and modalities designed to improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

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 physical 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 before or during your treatment session.

I consent to Teleheath Physical Therapy due to the shelter in place orders from the COVID-19 pandemic.

I acknowledge that my treatment program has been explained to me by my physical therapist, and 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**

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COVID-19 Pandemic Treatment Consent Form

I, _____, knowingly and willingly consent to have physical therapy treatment completed during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not, given the current limits in virus testing.

- I understand that due to the frequency of visits of other physical therapy patients, the characteristics of the virus, and the characteristics of physical therapy procedures, that I have an elevated risk of contracting the virus simply by being in Rise Physical Therapy and Pilates. _____ (Initial)
- I have been made aware that the California Department of Public Health has allowed physical therapist to continue treatment. _____(Initial)

I confirm that I am not presenting any of the following symptoms of COVOID-19 listed below:

- Fever
- Shortness of Breath
- Dry Cough
- Runny Nose
- Sore Throat
- Changes in sense of smell
- _____ (Initial)

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus, and the CDC recommends quarantining for a period of 14 days to anyone who has. _____ (Initial)

- I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by COVID-19. _____ (Initial)
- I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days. _____(Initial)
- I verify that if I do choose to travel by commercial airline, bus, or train that I will not return to Rise Physical Therapy and Pilates for 14 days. _____(Initial)

Signature_____

Date_____

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Cancellation Policy

If you are unable to keep a scheduled appointment, please give us at least 24 hours notice. Failure to give 24 hours notice will result in a $50 late cancellation fee.

Patient Name (printed) : _____
Patient Signature: _____
Date: ___ / ___ / _____

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Patient Goals:

What is one (or more) thing(s) that you could do 2 months ago that you can't do now due to your pain, weakness or limitation?

What are your goals for Physical Therapy?

Do you have any specific concerns regarding physical therapy that you would like your provider to be aware of?