



**North Tahoe Physical Therapy**

Medical History

Name \_\_\_\_\_ Date \_\_\_\_\_

1) Please describe the condition for which your are coming to Physical Therapy.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2) How did it start? When did it start?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3) What is your current pain level? 0-----5-----10

4) What is your current functional level? 0-----5-----10

5) Is the condition getting better? \_\_\_\_\_ Worse \_\_\_\_\_ No change \_\_\_\_\_

6) Past treatment for this condition \_\_\_\_\_

7) Goals for therapy \_\_\_\_\_

8) Activities which are limited by this condition

walking      dressing      sitting      standing      sleep      reaching      driving  
 lifting      intercourse      working      sports      other \_\_\_\_\_

**Current Medications**

Name of Drug	Reason for use	Name of drug	Reason for use
1		6	
2		7	
3		8	
4		9	
5		10	

**List all surgeries and date**

Surgery	Date	Surgery	Date
1		4	
2		5	
3		6	

Allergies: Latex \_\_\_\_\_ other \_\_\_\_\_

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

**North Tahoe Physical Therapy**

**Past Medical History:** Check all that apply

Heart Disease	Diabetes	Scoliosis
High Blood pressure	Thyroid condition	Back/neck pain
Pacemaker	Parkinsons/alzheimers	Broken bones
Stroke	Cancer	Fibromyalgia
Lung Disease, asthma	Mental Illness	Difficulty urinating
Chronic cough	Kidney disease	Irritable Bowel Syndrome
TB	Urinary or Fecal leakage	Others: please list
Sexually transmitted disease	Painful intercourse	
HIV/AIDS	Sexual abuse	

Social history

Do you live alone? \_\_\_\_\_ with spouse \_\_\_\_\_ other \_\_\_\_\_

Do you exercise on a regular basis? Y\_\_N\_\_ What type? \_\_\_\_\_

Amount of stress: Circle one: At home: low, medium, high At work: low medium high

Any other history you would like to discuss?

---



---



---



---

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

**North Tahoe Physical Therapy**

Privacy Act : I authorize North Tahoe Physical Therapy to release or obtain the information necessary to provide my treatment and process the claim. I understand that this information will not be shared unnecessarily and is protected under HIPPA.

Patient Initials \_\_\_\_\_

Consent to Treat: I consent to Physical Therapy treatment at North Tahoe Physical Therapy. In doing so, I understand that such therapy may involve bodily contact, touching and/or direct contact of a sensitive nature. I understand that these procedures will be fully explained before they are provided and that I have the right to refuse or stop and treatment at any time without fear of judgement or other repercussions.

Patient initials \_\_\_\_\_

Attendance Policy: We require cancellations to be made 24 hours in advance. I understand that if I fail to show for my appointment or if I cancel less than 24 hours in advance that I will be subject to a \$40 cancellation fee. Repeated cancellations and no shows will result in the need for a re-evaluation. Emergencies or weather related cancellations are exempt from cancellation fees. Active therapy requires visits to be spaced no more than 30 days apart. If you do not attend therapy within 30 days of your last visit, you must obtain another referral from your doctor.

For personal training , the full price will be charged. For massage and myofascial release , you will be charged 50% of the cost of the service for a no show/less than 24 hour cancellation.

Patient initials \_\_\_\_\_

Billing policy:

- \* I understand that I am fully responsible for my physical therapy visits and agree to pay my deductible, co-insurance and co-payment and any charges not reimbursed by my insurance company.
- \* I accept responsibility to know my insurance company's limits and requirements. I understand that my insurance policies are a contract between the insurance carrier and myself. I further understand that North Tahoe PT checks my benefits as a courtesy but does not guarantee accuracy or payment from my insurance carrier.
- \* I agree to pay my co-payment and co-insurance each visit before my treatment.
- \* If my deductible has not been met, I must pay a minimum of \$100 each visit as a deposit towards the final bill. I may have a balance due to North Tahoe PT after the insurance has processed the claim.
- \* I agree to pay all other charges within 90 days of receiving the bill. I understand that any balances which are outstanding after 90 days are subject to interest at 18% which I agree to pay.
- \* I understand that some insurance companies require reauthorization or have reimbursement limits on physical Therapy. I understand that I am responsible for knowing and meeting these requirements.
  - \* \_\_\_ I have already checked my insurance benefits
  - \* \_\_\_ I will check my insurance benefits myself

( We can provide you with a form to assist you in checking your benefits, if needed)

\* I have received a copy of this form

Patient signature \_\_\_\_\_ Date \_\_\_\_\_