BODY EASE
PHYSICAL THERAPY

Please complete ALL information to the best of your ability. All information we collect will be kept confidential and will only be shared with your physicians, insurance, &/or attorney per your authorization or court order. BLACK INK ONLY PLEASE.

Patient Name: _____

(last) (first) (MI) (nickname)

Social Security #:_____ Sex: M/F Marital Status: ☐ M ☐ S ☐ D ☐ W

Mailing Address: _____ Date of Birth: _____

City: _____State: _____ Zip: _____ Age: _____

Home Phone #: _____ Voice Call reminder of appt? ☐ Yes ☐ No

Cell Phone #: _____ Text reminder of appointment? ☐ Yes ☐ No

Email: _____ Email reminder of appointment? ☐ Yes ☐ No

Employer Name _____ Occupation: _____

Employer Address: _____

Referring Physician: _____ Practice Name: _____

Parent/Guardian (Please circle)

Name _____ Contact #: _____

Primary Insurance Company: _____ Policy ID: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Secondary Insurance Company: _____ Policy ID: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Worker's Comp Ins: _____ Claim #: _____

Address, Phone #, Fax # (if you have it): _____

_____

Date of Injury: _____ Case Manager's Name: _____ Ph#: _____

Attorney's name, address, & Ph#: _____

Emergency Contact/Relation: _____ Phone #: _____

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Are you receiving or have you received home health services? ☐ Yes ☐ No

Are you receiving or have you received other therapy services? ☐ Yes ☐ No

How did your pain start? Was it an injury or did it just come on gradually for no particular reason? If it was due to injury, please explain in detail. _____

_____

_____

Date of injury: _____

Have you had anything like this before? ☐ Yes ☐ No

If this is a chronic problem, what usually brings it on? _____

Just prior to this onset, were you free of symptoms? ☐ Yes ☐ No

What, if any, treatments have you had for this problem? _____

Did the above treatment help? ☐ Yes ☐ No

Please provide a complete list of all current medications and supplements including: name, dosage, and frequency. Please use back page if needed. _____

_____

_____

List any surgeries with dates you have had. Use back page if needed. _____

_____

_____

Serious illnesses or conditions: _____

When? _____

Have you had any falls recently? ☐ Yes ☐ No

If yes, describe: _____

_____

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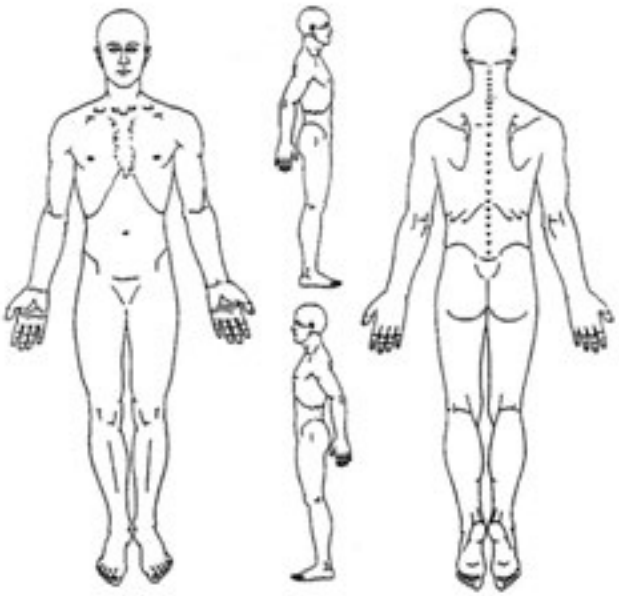
Weight: _____

Height: _____

Please shade all areas of pain or numbness.



Intensity: On a scale of 0 to 10 (0 being no pain and 10 being severe), circle number that best describes pain.

At Worst: 0 1 2 3 4 5 6 7 8 9 10

Current: 0 1 2 3 4 5 6 7 8 9 10

At Best: 0 1 2 3 4 5 6 7 8 9 10

Describe pain: Sharp Dull Ache Burn Tingle Numb

Pain is made worse by: Sitting Lying Prolonged standing Bending Stairs
When first arising As the day goes on Other _____

Pain is made better by: Sitting Lying Prolonged standing Bending Stairs
When first arising As the day goes on Other _____

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Consent for Treatment

I hereby consent to evaluation and treatment by Body Ease Physical Therapy Centre as ordered by my physician(s). I also understand that I have the right to refuse treatment at any time.

Financial Responsibility

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself, not between my insurance company and this office. I authorize my health insurance company to make payment directly to Body Ease Physical Therapy Centre for any physical therapy services I receive. I am aware that benefits provided by my insurance are NOT a guarantee of payment and that I AM ULTIMATELY RESPONSIBLE FOR ALL CHARGES INCURRED DURING TREATMENT. All bills are considered the responsibility of the patient or guardian, and payments are due the day of service unless other arrangements have been made. Accounts beyond 90 days delinquency will be sent to collections and a 25% collections charge &/or attorney fees incurred will be the responsibility of the patient/guarantor.

Cancellation/No-Show Policy: In order to accommodate the needs of all of our patients, Body Ease requires 24-hr notice for the cancellation of a scheduled appointment. Should you fail to notify us within the allotted amount of time, you may be subject to a $35.00 charge. This fee is the responsibility of the patient and not billable to insurance. We understand that emergencies do occur that may not fall under these terms.

Consent for Disclosure

I authorize the release of any information relating to my treatment to my physician(s) as well as my insurance company to facilitate payment of my account.

I acknowledge receipt or have been offered a copy of the Privacy Practices from Body Ease Physical Therapy Centre. See copy posted in waiting area or ask staff for your own.

I have read and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____Date: ____/____/_____

Witness Signature: _____Date: ____/____/_____