Transformation Physical Therapy

# 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.

**Payment:** Payment is due at the time of service.

**No warranty: I understand that my physical therapist at Transformation Physical Therapy, LLC 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.

---

**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.**

______________________________ Print name

____________________ Date

______________________________
Patient's signature (if minor, parent or legal guardian must sign)

# MEDICAL HISTORY

Client/Patient: ________________________________________Home Phone: (   )___________________________

Date of Birth: _________Age: _____Work Phone: (   )________________Cell Phone: (   )_____________________

Address:_____________________________________________City:______________State:________Zip:_________

Email Address:__________________________________________________________

Employer:_____________________________________________________________________________________
Address State Zip

Emergency Contact: Name_____________________________________Phone #:____________________________

Address:________________________________________________________________________

Your goals for physical therapy:_________________________________________________________________

Athletic goals:___________________________________How did you hear about us?_______________

Referring Physician:___________________________________Phone: (   )__________________________________

Address:_____________________________________________________________________________________

When do you see your physician again?___________________

Primary Care Physician:________________________________Phone: (   )__________________________________

Type of Injury/Condition:_______________________________________Onset/Injury Date:__________________________

Physical limitations due to injury______________________________________________________________________

What activities aggravate your symptoms?_______________________________________________________________

Type of Surgery & Date:_______________________________________

Describe any previous treatment for this condition:

_______________________________________________________

**Have you had any diagnostic tests for this condition?**

X-ray CT scan MRI Doppler Ultrasound

Please describe your pain: Sharp / Burning / Aching /

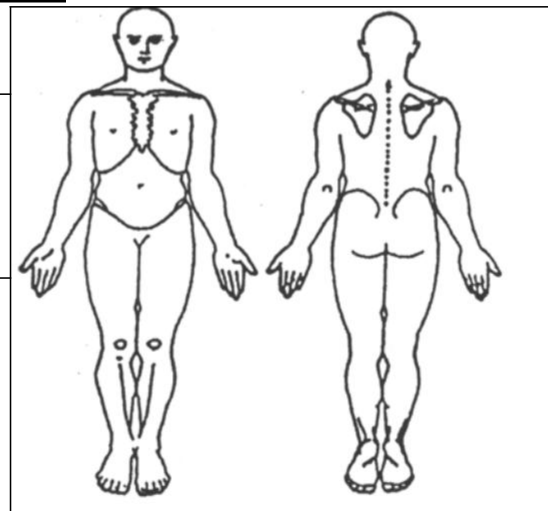
Tingling / Numbness / Other_______________________________

Please rate your pain (0 = none, 1 = minimal, 10 = severe):

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

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

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



**Please mark the location of your symptoms**

Are you currently taking medications? Yes / No. Please list meds: ______________________________________________

_____________________________________________________________________________________________________

**Have you recently noted any of the following?**

- ❒ Breathing Difficulty
- ❒ Change in Vision
- ❒ Fatigue
- ❒ Fever/Chills/Sweats
- ❒ Headaches
- ❒ Insomnia
- ❒ Nausea/Vomiting
- ❒ Pain at Night
- ❒ Pregnancy
- ❒ Weakness
- ❒ Weight Loss

**Do you have now or have you ever had any of the following?**

- ❒ Allergies/Skin Sensitivity
- ❒ Asthma/Breathing Problems
- ❒ Autoimmune Deficiency
- ❒ Cancer
- ❒ Circulation Problems
- ❒ Diabetes
- ❒ Easy Bruising/Bleeding
- ❒ Fainting
- ❒ Fractures
- ❒ Heart Problems
- ❒ Hepatitis
- ❒ High Blood Pressure
- ❒ Indigestion/Heartburn
- ❒ Kidney Disease
- ❒ Leg/Ankle Swelling
- ❒ Loss of Consciousness
- ❒ Lung Disease
- ❒ Metal Implant
- ❒ Motor Vehicle Accident
- ❒ Multiple Sclerosis
- ❒ Osteoporosis/Osteopenia
- ❒ Sprains/Strains
- ❒ Stroke
- ❒ Surgeries
- ❒ Thyroid Problems
- ❒ Urinary Problems/Infections

❒ Any previous injury that may affect current care? Please describe: ____________________________________________

Please explain & give approximate dates for any conditions marked above. ________________________________________

________________________________________________________________________________

________________________________________________________________________________

# Transformation Physical Therapy, LLC

## HIPAA REGULATIONS

### 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.

### Our 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

To follow are 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.

If you have any question about any of our policies or your rights, please feel free to speak with your physical therapist.

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

________________________________________ ____________________

Printed Name Date

________________________________________

Signature