absolutetherapycare

10125 Verree Road Suite 100
Philadelphia, PA 19116

| **PATIENT INFORMATION** | | | **EMAIL ADDRESS:**_____ |
|---|---|---|---|
| First Name: | Last Name: | Middle Initial: | Date: / / |
| Address: | City: | State: | Zip: |
| Birth date: / / | Age: | ☐ Male ☐ Female | S.S. #: - - |
| Home Phone: ( ) - | Alternative Phone (Cell, Pager): ( ) - | | Spouse: |
| Chose Clinic Because/ Referred to Clinic By ☐ Dr.: | | ☐ Insurance Plan ☐ Family ☐ Friend | |
| ☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other: | | | |

| **WORK INFORMATION** | | |
|---|---|---|
| Employer: | Work Phone ( ) - | Ext. |
| Occupation: | Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed | |

| **CARE PROVIDER INFORMATION** | |
|---|---|
| Referring Dr: | Referring Dr. Phone: ( ) - |
| Regular Dr./PCP | Regular Dr./PCP Phone: ( ) - |

| **INSURANCE INFORMATION** | **(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST )** |
|---|---|
| Primary Insurance Name: | |
| Subscriber's Name (If different): | Birth date : / / |
| ID. #: | Group/Policy # |
| Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: | |
| Name of Secondary Insurance: | |
| Subscriber's Name: | Birth date : / / |
| ID. #: | Group/Policy # |
| Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: | |

| **AUTO OR WORK INJURY CLAIM** | **(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP )** |
|---|---|
| Insurance Name: ☐ Auto : | ☐ Labor & Industries: |

| | | | |
|---|---|---|---|
| Adjuster/Claim Manager: | Phone: | Ext.: | |
| Address: | City | State: | Zip: |
| Claim #: | Accident Date: / / | Cause: | |

| **ATTORNEY INFORMATION** | | | |
|---|---|---|---|
| Name: | Law Firm: | Phone: ( ) - | |
| Address | City | State: | Zip: |

| **IN CASE OF EMERGENCY** | | |
|---|---|---|
| Name of Local Friend or Relative (Not Living at Same Address): | | |
| Relationship to Patient: | Home Phone: ( ) - | Work Phone: ( ) - |

I authorize my insurance benefits be paid directly to absolute therapy care. I understand that I am financially responsible for any balance. I also authorize _____ to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

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# PAST MEDICAL HISTORY FORM

**Patient Name** _____

| BLOOD PRESSURE | YES | NO |
|---|---|---|
| Hypertension | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ |
| Normal Blood Pressure | ☐ | ☐ |

| HEART DISEASE | YES | NO |
|---|---|---|
| Heart Attack | ☐ | ☐ |
| Atherosclerotic Disease | ☐ | ☐ |
| Myocardial Infarction | ☐ | ☐ |
| Rheumatic Heart Disease | ☐ | ☐ |
| Heart Murmur | ☐ | ☐ |
| Do you have a pacemaker | ☐ | ☐ |

| MUSCLE CONDITION | YES | NO |
|---|---|---|
| Carpal Tunnel R/L | ☐ | ☐ |
| Tennis Elbow R/L | ☐ | ☐ |
| Back/Neck Problems | ☐ | ☐ |
| Limited Limb Movement | ☐ | ☐ |

| LUNGS | YES | NO |
|---|---|---|
| Asthma | ☐ | ☐ |
| Emphysema | ☐ | ☐ |
| Shortness of Breath | ☐ | ☐ |

| JOINT CONDITIONS | YES | NO |
|---|---|---|
| Upper Extremity | ☐ | ☐ |
| Dislocation | ☐ | ☐ |
| Lower Extremity Dislocation | ☐ | ☐ |

| OTHER CONDITIONS | YES | NO |
|---|---|---|
| Muscular Dystrophy | ☐ | ☐ |
| Rheumatoid Arthritis | ☐ | ☐ |
| Multiple Sclerosis | ☐ | ☐ |
| Epilepsy | ☐ | ☐ |
| Gout | ☐ | ☐ |
| Fibromyalgia | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Hearing Loss | ☐ | ☐ |
| Poor Eyesight | ☐ | ☐ |
| Fainting | ☐ | ☐ |
| Polio | ☐ | ☐ |

Other: _____

| EXERCISE | WORK ACTIVITY | STRESS LEVEL | HABITS | |
|---|---|---|---|---|
| ☐ None | ☐ Sitting | ☐ Low | ☐ Smoking | Packs a Day _____ |
| ☐ 1-2 x Week | ☐ Standing | ☐ Medium | ☐ Alcohol | Drinks a Week _____ |
| ☐ 3-4 x Week | ☐ Light Labor | ☐ High | ☐ Coffee/Soda | Cups a Week _____ |
| ☐ 5+ x Week | ☐Heavy Labor | | | |

What types of exercise do you perform? : _____

What things cause stress in your life? :

Are you taking any seizure medication? ☐YES ☐NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐YES ☐NO If yes list name: _____

List all medications you are currently taking: _____

List all surgeries in the past two years (Including dates): _____

Are you pregnant? ☐ YES ☐ NO What week?: _____

Have you had any injuries related to work? ☐ YES ☐ NO If yes list body part and date.: _____

Have you had any Auto Accidents ☐ YES ☐ NO If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? ☐ YES ☐ NO Where:

_____

Signature of Patient, Parent, Guardian, Personal Representative

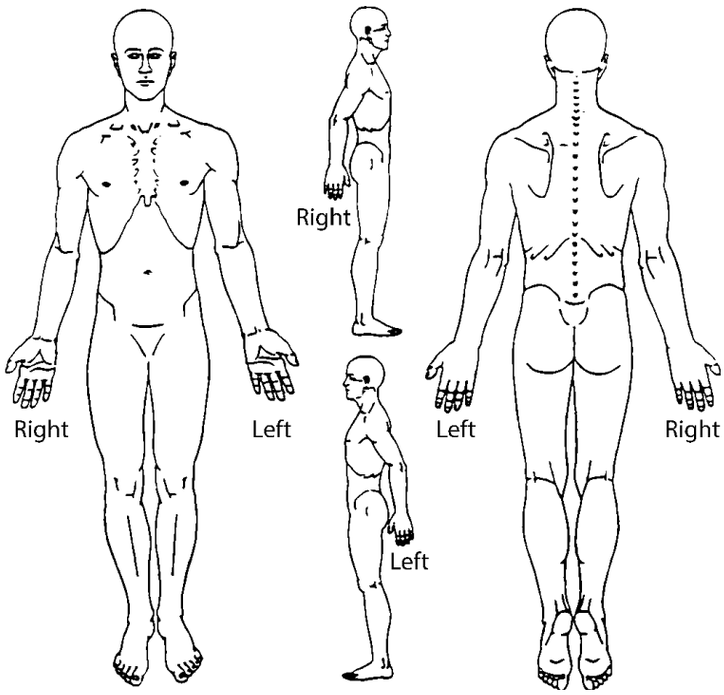
Date

## *Pain and Symptom Status Report*

Name Date

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing.

| Ache | Burning | Numbness |
|---|---|---|
| MMMM | – – – | ▯▯▯▯ |
| MM | – – | ▯▯▯ |
| **Pins & Needles** | **Stabbing** | **Other** |
| ▯▯▯▯▯▯▯▯ | / / / / / / / / | X X X X |
| ▯▯▯▯▯▯ | / / / / / | X X X |




## *Chief Complaint and Visual Analog Scale*

My Chief Complaint is:

Date First Symptom of Your Problem Occurred on:

2nd Complaint:

3rd Complaint:

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Please circle on the scale below to indicate your <u>CURRENT</u> level of pain:** | | | | | | | | | | | | |
| **No Pain** | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **Pain as bad as it gets** |
| **Please circle on the scale below to indicate your <u>AVERAGE</u> level of pain:** | | | | | | | | | | | | |
| **No Pain** | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **Pain as bad as it gets** |
| **Please circle on the scale below to indicate your <u>WORST</u> level of pain:** | | | | | | | | | | | | |
| **No Pain** | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **Pain as bad as it gets** |

Additional Comments:

| absolutetherapycare | 10125 Verree Road Suite 100<br>Philadelphia, PA 19116 |
|---|---|

## CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information will be used by this practice, known as absolute therapy care or disclosed to others for the purpose of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

We are providing you with a copy of our Notice of Privacy Practices. We request that you review the notice prior to signing this consent. You may request a restriction on the use or disclosure of your protected health information. If you wish to restrict your disclosure, you should make that request in writing.

This practice, however, may or may not agree to restrict the disclosure of your protected health information.

If we agree to your request, the restrictions will be binding. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

You may revoke the consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received will not be affected.

This practice reserves the right to modify the privacy practices outlined in the notice.

**SIGNATURE**

I have reviewed this consent form and have reviewed the Notice of Privacy Practices. I give my permission to this practice to use and disclose my health information in accordance with it.

Name of Patient (Print Clearly)

Signature of Patient  Date

Signature of Patient Representative

Relationship of Patient Representative to Patient