CURE
Physical Therapy & Wellness Center

Patient Information Sheet

Patient Name:_____Date:_____

Address:_____ City:_____ Zip:_____

Birthdate:_____ Age:_____ Gender: ☐ Male ☐ Female

Home Phone:_____Alt. Phone: _____ E-Mail: _____

☐ I would like to receive our CURE newsletter and other information via E-mail

Primary Insured

Name:_____ Relationship:_____ Birthdate:_____

Address:_____ City:_____ Zip:_____

Home Phone:_____Alt. Phone: _____ E-Mail: _____

Emergency Contact

Contact Person:_____ Phone:_____

Authorization to release medical information to this individual: ☐ Yes ☐ No

Referring Physician

Referring Doctor:_____ Primary Care Physician:_____

Consent of Treatment / Assignment of Benefits

I herby consent to and authorize all treatment considered medically necessary or advisable by the physician and physical therapist. I understand that the Physical Therapist (PT) or Physical Therapy Assistant (PTA) may provide various portions of my treatment as so advised by the physician. I authorize payment directly to Cure Physical Therapy and hereby agree that I am financially responsible for any services rendered and for charges or supplies not covered by this assignment. I authorize release of my medical information for billing purposes.

_____

Print Name

_____ _____

Signature (Parent or Legal Guardian if Patient under 18) Date

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Physical Therapy Questionnaire / Evaluation

Name: _____ Date: _____ Problem Area: _____

Please describe briefly the history of your current illness or injury: _____

_____

_____

Are you or is there a possibility you are pregnant? YES NO

Do you smoke? YES NO If yes, how much do you smoke per day? _____

Please list your current medications or attach list:

_____

_____

Please list past surgical history with an approximate date:

_____

_____

Past Medical History: Please circle each condition that you have been told you have /think you have:

Cancer	High Blood Pressure	Osteoporosis
Allergies/ Asthma	Diabetes	Heart Disease
Osteoarthritis	Lung Disease	Kidney Disease
Angina/Chest Pain	Rheumatoid Arthritis	Liver Disease
Stroke	Fibromyalgia	Pacemaker
Metal Implants	Depression	Claustrophobia

Are you currently suffering from any of the following (circle) Yes No

Unexplained weight loss	Difficulty swallowing	Changes in appetite
Changes in bowel or bladder function	Nausea / Vomiting	Fever/ Chills/ Sweats

Approximately when did your current complaints start: _____

Have your symptoms been: Getting worse Getting better Staying the same

What treatments have you had for this condition: _____

What makes your symptoms better: _____

What makes your symptoms worse: _____

Have you had an X-ray / MRI / other imaging? Yes No

Please circle what has been your AVERAGE pain level:

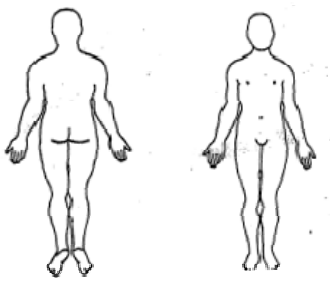
No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain**

Other Comments: _____

_____

Body Chart

Please Mark Your Areas of Pain



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Acknowledgement of Notification of Patient Privacy Rights

I have been issued a copy of Cure Physical Therapy's notice of patient privacy practices delineating how my information, under the state of federal rules and regulations, will disclose my personal health information.

_____
Print Name

_____ _____
Sign Name (If patient under 18 please have legal guardian or parent sign) Date

Appointment Policy

I understand my physician has prescribed physical therapy for my condition and regular attendance/participation is needed to maximize my progress. I, to the best of my ability, will attempt to give **24 hour notice** prior to any cancellation. Furthermore, if I cancel/no show 3 appointments all remaining appointments may be cancelled and future visits will be scheduled individually. I may also possibly be discharged from physical therapy care due to non-compliance. If I am more than 10 minutes late I may have an abbreviated treatment and possibly have the appointment cancelled and re-scheduled.

_____
Print Name

_____ _____
Sign Name (If patient under 18 please have legal guardian or parent sign) Date