PhysioFixx Physical Therapy
7290 Navajo Rd suite 111 San Diego, CA 92119

Patient name: _____Email:_____Today's Date: _____

Date of Birth: _____Occupation:_____Primary Physician_____

How did you hear about us? ☐My Doctor ☐Website ☐Social Medial ☐Friend/family ☐Community posting ☐Postcard ☐Walked by

Please tell us about the condition or injury that you are currently seeking Physical Therapy treatment for

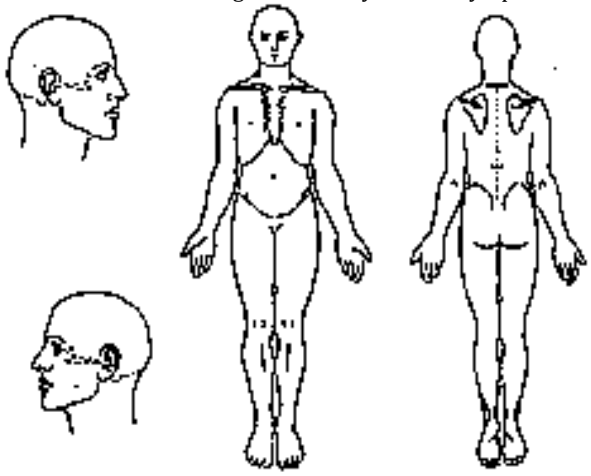
When did you first notice pain or limitation due to this injury/condition? (Provide approximate dates) _____

Is this a flare up of symptoms? Y ☐ N ☐ If yes, when? _____Date of surgery (if applicable)?_____

In your opinion, what is the cause of your limitation, injury or condition? _____

What goals do you want to achieve with your Physical Therapist? _____Do you Exercise? Yes No How Often? _____

Indicate on the diagram where you have symptoms



Please rate your pain using this pain scale by circling *two* numbers
(0 = no pain at all 10= Worst pain imaginable)
Worst pain I have had in the last week: 0 1 2 3 4 5 6 7 8 9 10
Best pain I have had in the last week: 0 1 2 3 4 5 6 7 8 9 10

Are your symptoms: ☐ Constant ☐ Intermittent ☐Improving ☐ Getting Worse

What makes your symptoms worse? _____

What makes your symptoms better? _____

Who have you seen for this injury or condition? ☐ Family Doctor ☐ENT ☐Dentist ☐ Orthopedist ☐ Neurologist ☐Pain Management ☐ Psychiatrist

***For this injury or condition* what diagnostic tests have you had?**
☐X-Ray ☐MRI ☐CT Scan ☐Tomograph

Please indicate any treatments you have had or are currently receiving from another practitioner *(provide dates if possible).*
Injection: _____ Acupuncture: _____ Chiropractic: _____ Massage: _____ Physical Therapy: _____
Other:_____ Have you experienced any changes with any of these treatments ? ☐Y ☐N

Please indicate below which activities you are having pain or difficulty with

- ☐ Drinking or eating
- ☐ Dressing: ☐shoes ☐pants ☐OH shirt ☐jacket ☐bra
- ☐ Showering
- ☐ Maintaining head bent forward (reading, computer)
- ☐ Turning head
- ☐ Reaching: ☐OH☐ behind back ☐down☐ forward
- ☐ Getting in & out of ☐chairs ☐bed☐ car ☐shower
- ☐ Rolling or moving in bed
- ☐ Gripping ☐holding objects ☐opening jars
- ☐ Caring for child or adult
- ☐ Other:_____
- ☐ Walking ☐Flat ground ☐Uneven surfaces ☐Inclines
- ☐ Navigating: ☐Stairs ☐Curbs ☐Ladders
- ☐ Standing
- ☐ Sitting
- ☐ Bending ☐Squatting☐ kneeling
- ☐ Lifting Carrying
- ☐ Driving
- ☐ Household Activity☐ Yard Work
- ☐ Recreational Activities: _____
- ☐ Job Related Activities: _____
- ☐ Other: _____

Comments:_____
_____

MEDICAL HISTORY

Do you currently have or have you ever been diagnosed with any of the following?

Heart Condition	☐ No	☐ Yes	Cancer	☐ No	☐ Yes	Arthritis	☐ No	☐ Yes
High Blood Pressure	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes	Osteoporosis	☐ No	☐ Yes
Stroke	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes	Tuberculosis	☐ No	☐ Yes
Pacemaker	☐ No	☐ Yes	Epilepsy	☐ No	☐ Yes	Infection/Illness	☐ No	☐ Yes
Respiratory Disease	☐ No	☐ Yes	HIV	☐ No	☐ Yes	Other: _____		

Please list *all* medications you are currently taking including frequency and Dosage (include over the counter and supplements on reverse if needed)

_____

Do you have an immediate family history of?

Cancer: ☐ No ☐ Yes Heart Disease: ☐ No ☐ Yes Diabetes: ☐ No ☐ Yes Depression or Suicide: ☐ No ☐ Yes

Are you currently or have you recently been experiencing any of the following?

☐ Difficulty Sleeping	☐ Dizziness	☐ Difficulty Breathing
☐ Fatigue	☐ Balance Problems	☐ Changes in pain relative to eating
☐ Unexplained weight Change	☐ Headaches	☐ Changes in bowel or bladder function
☐ Fever, chills, or night sweats	☐ Visual Disturbances	☐ Sexual Dysfunction
☐ Nausea or Vomiting	☐ Difficulty swallowing or speaking	☐ Loss of sensation in genital region

If you answered yes to any of the above symptoms is your doctor aware of it? □ No □ Yes

If you answered yes to any of the above, what is your belief as to the cause of these symptoms?_____

Have you fallen in the last year? □ No □ Yes Have you fallen and hurt yourself in the last year? □ No □ Yes

During the past month have you often been bothered by feeling down, depressed or hopeless? ☐ Yes ☐ No

During the past month have you often had little interest or pleasure in doing things you used to enjoy? ☐ Yes ☐ No

If you answered yes, would you like help for this? ☐ Yes ☐ Yes, but not today ☐ No

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CONSENT TO TREAT

I grant permission to PhysioFixx to perform an evaluation and procedures necessary to assess and treat my condition or injury. During the evaluation and the course of my treatment the nature of the procedures that will be performed as well as any potential risks will be explained to me.

_____I understand that I am entering the practice to receive a physical therapy evaluation and treatment to correct or *rehabilitate* my condition.

_____I understand that I am entering the practice ***without a diagnosis from my medical doctor*** to receive an evaluation and treatment. In the state of California a Physical Therapist can provide A Physical Therapy in treatment without a diagnosis from a medical doctor with certain limitations.

_____I understand that I am entering the practice to receive a physical therapy evaluation and wellness/fitness services. Wellness services are not meant to rehabilitate an injury or condition but instead provide interventions for optimal health and wellness.

The Physical Therapist will discuss these services at the time of the evaluation to determine which service is most appropriate.

_____

Patient Signature (Guardian if under 18 years of age) Date

My signature indicates that I understand the information above and I voluntarily give my consent to be treated as explained.

Cancellation Policy

PhysioFixx Physical Therapy strives to provide the best possible care for you and your family. Attending your scheduled appointments is a necessary part of a successful treatment plan. If you are not able to make an appointment, we ask that you provide a 24 hour cancellation notice to our office before the scheduled appointment. *For late cancellations, we reserve the right to charge you for the full cost of the appointment.*

Initial_____

Financial Policy

Payment for service is due at the time of service. Financial obligations will be explained prior to the appointment time. If you need special payment arrangements please discuss this with the business manager prior to starting your treatment. At the conclusion of your care with PhysioFixx Physical Therapy, you may be billed for any outstanding balances, including any fees for missed appointments that were incurred over the course of the treatment period.

Initial_____

HIPAA (Health Insurance Portability and Accountability Act)

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those in need of your health care information (information about treatment, payment or health care operations) in order to provide health care that is in your best interest.

Copies of the full version of the HIPAA notice are available for your records. Please request from the front desk. Read the full version of your rights under HIPAA before signing below.

_____

Patient Signature (Guardian if under 18 years of age) Date

I have read the HIPAA Notification and understand my rights under the Health Insurance Portability and Accountability Act.

If at any time you feel the privacy of your health information has not been protected, contact the Privacy Officer at (619)-535-6964.