

Patient Information



Yorktown
Physical
Therapy

First Name		Last Name		M	
Street Address					
City		State		Zip Code	
Home Phone		Cell Phone			
Work Phone		E-mail			
Date of Birth		Male	<input type="checkbox"/>	Female	<input type="checkbox"/>
SS#:					
Are you interested in receiving our informative newsletter?					Yes <input type="checkbox"/>

Emergency Contact	
First Name	Last Name
Emergency Contact Primary Phone:	

Subscriber (Insured) Information <i>Please fill out if someone other than you.</i>					
First Name		Last Name		M	
Street Address					
City		State		Zip Code	
Relationship		Date of Birth		Male	<input type="checkbox"/>
				Female	<input type="checkbox"/>

Worker's Comp ONLY: Employment Information	
Employer	Town/City

Minors ONLY: Responsible Party Information	
First Name	Last Name
Street Address	
City	State
Phone	Zip Code

Release of Authorization/Assignment of Benefits:	
<p>I authorize the release of medical information necessary to process my insurance claim(s). I authorize the request for payment of medical benefits directly to Yorktown Physical Therapy and its mother company Elevate Physical Therapy PLLC. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.</p>	
Signature:	Date

Medical History



Name:		Referring Physician:	
Primary Care Physician:		Date of Last Visit:	
Height:		Weight:	
		Hand Dominance:	Right <input type="checkbox"/> Left <input type="checkbox"/>

Have you noted any of the following in the past three months (Check all that apply)?

<input type="checkbox"/> Pain at Night	<input type="checkbox"/> Weight loss/gain	<input type="checkbox"/> Changes in Appetite
<input type="checkbox"/> Weakness/Fatigue	<input type="checkbox"/> Headaches	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Nausea/ Vomiting	<input type="checkbox"/> Changes in bowel or bladder function	

For Women: Are you currently or think you might be pregnant? Yes No

Have you ever been diagnosed with any of the following (Check all that apply)?

<input type="checkbox"/> Anemia	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer (Please explain below)
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes: Type I or Type II (circle)
<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Heart Disease (i.e. CHF)	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Kidney/Liver Disease	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Osteoporosis/Osteopenia	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Stroke (CVA, TIA)	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

Please use this section to explain the above further:

Surgical History

Please list surgeries you have had and include the dates:

Surgery	Date	Surgery	Date
1		2	
3		4	

Current Injury or Condition:

When did your symptoms begin? _____

How did your symptoms begin? _____

In the Past 7 days, Please rate the **Best/Lowest** your pain has been: (Circle)

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

What makes your pain better? _____

In the Past 7 days, Please rate the **Worst/Most** your pain has been: (Circle)

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

What makes your pain worse? _____

Please Note where your symptoms are located

SYMBOLS TO USE

- Aching: $\triangle\triangle\triangle$
- Numbness: $====$
- Pins & Needles: ooo
- Burning: xxx
- Stabbing: $///$
- Radiates: $\rightarrow\rightarrow\rightarrow$

Labels on diagrams: Grain, SI (Sacroiliac), Buttocks, Mid Back, Low Back, Legs

Please list all current Medications: (Please include frequency and dosage)

Patient/Guardian Signature: _____ Date: _____



Patient HIPAA Awareness

With my permission, Yorktown Physical Therapy may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations.

Yorktown Physical Therapy always has a copy of the Notice of Patient Information Practices available. Yorktown Physical Therapy reserves the right to revise the Notice of Patient Information Practices at any time.

With my permission, Yorktown Physical Therapy may call my home or other designated locations and leave a message on voicemail or in person, in reference to any item that would assist the practice in carrying out treatment, payment and healthcare operations, such as appointments reminders or insurance items.

With my permission, Yorktown Physical Therapy may mail to my house or other designated locations any item that assists the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder sheets, and patient statements.

With my permission, Yorktown Physical Therapy may e-mail or fax myself or my physician any item that assists the practice of carrying out treatment, payment and healthcare operations, such as progress reports or plans of care.

By signing this, I am allowing Yorktown Physical Therapy and Elevate Physical Therapy PLLC to use and disclose my protected health information for treatment, payment and healthcare operations. I have also been shown the Notice of Patient Information Practices and have the right to request a copy at any time.

Patient or Legal Guardian Signature

Print Name

Date



Cancellation and No Show Policy

Thank you for choosing Yorktown Physical Therapy to provide your physical therapy services.

In the event that you cancel an appointment with less than 24 hours notice or do not show for an appointment, a fee of \$40 will be charged to you. As a courtesy we will not charge you this for the first occurrence.

If you are more than 15 minutes late for an appointment, you may need to be rescheduled or incur a \$40 fee.

Please be aware that your insurance company will not pay this fee, and thus is your responsibility.

This policy is not in effect in times of bad weather. We define this as days when schools are closed because of bad weather.

We regret having to institute this policy and appreciate your understanding in this manner.

I understand and agree to comply with the above policy.

Patient's Signature

Date