PATIENT INFORMATION

Today's Date:___________________

Name:____SS#:________-________-________
First Middle Last **(REQUIRED FOR WORK COMP & VA ONLY)**

☐ Male ☐ Female Date of Birth____/____/____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address:____
Street Address City State Zip

Email Address:____Fax: (______) ______-_______________

Would you like to receive appointment reminders by email? ☐ Yes, notify me by email ☐ No, Do not email me

Home Phone: (______) ______-_____________ ☐ Work or ☐ Cell Phone: (______) ______-_____________

Would you like to receive appointment reminders by text? ☐ Yes, notify me by text ☐ No, Do not text me

Driver's License #:______________________________State Issued:_______ **Please provide a copy for our records**

Employer:____ Occupation:________________________________
(REQUIRED FOR WORKER COMPENSATION CASES)

Emergency Contact:_____________________________ Phone: (______) ______-____________Relation:____________

Have you had Physical or Occupational Therapy this year for any condition? ☐ Yes ☐ No

PHYSICIAN INFORMATION

Referring Physician:____Date of Injury:_____________________

Office Address:____Phone: (______) ______-_____________
Street Address City State Zip

APPOINTMENT POLICY

I understand that my doctor has prescribed physical therapy for me and physical therapy is an on-going process which requires regular attendance to be optimally effective. I understand that if I am late for an appointment, I may have to reschedule my appointment or may have to accept an abbreviated treatment for that day. I understand that if I cancel or no show for three (3) consecutive appointments, MVP Physical Therapy has the right to discharge me from care for being non-complaint with my physician's orders.

I understand and agree that **MVP Physical Therapy** requires 24-hour advance notice of cancellation. If I fail to give 24-hour notice of cancellation or fail to show up for an appointment, I may be subject to a $25 charge (which is not covered by insurance)

Signature:____ Date:____________________________
(PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE)

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Legal Guardian

CONSENT FOR TREATMENT

I the Undersigned do hereby agree and give my consent for **MVP Physical Therapy** to furnish physical therapy care and treatment considered necessary and proper in evaluating and/or treating my physical condition. I also authorize MVP Physical Therapy to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

Signature:____ Date:____________________________
(PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE)

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Legal Guardian

WORKER COMPENSATION INFORMATION

TO BE FILLED OUT BY INJURED WORKER:
(ALL FIELDS REQUIRED)

Injured Worker's Name:____ Date of Injury:_____/_____/__________

SS#:____________-____________-____________ Claim #:____

Employer **(AT TIME OF INJURY)**:____

Employer Address:____

Street Address City State Zip

Employer Phone: (______) ______-_______________

WORKER'S COMPENSATION CARRIER/ATTORNEY INFORMATION

Carrier:____

Claims Mailing Address:____

Street Address City State Zip

Adjuster's Name:____

Ph: (______) ______-_______________ Extension:_________________ Fax: (______) ______-_______________

CM/NCM: Contact: ____

Ph: (______) ______-_______________ Extension:_________________ Fax: (______) ______-_______________

Attorney Name:____ Ph: (______) ______-_______________

Mailing Address: ____

Street Address City State Zip

NON-COMPLIANCE NOTIFICATION

Your therapist, physician, adjuster and case manager work together to assist with you return to full function in the workplace. In order for your treatment to have maximal effect and progress, all prescribed sessions must be attended. To comply with the workman's compensation laws, we are required to notify the adjuster, case manager and physician of missed appointments. If for any reason, you are unable to attend, please call in a timely manner and we will reschedule your appointment and inform your adjuster. Missed appointments may result in discontinuation of workman's compensation benefits.

I have read and understand the non-compliance notification. I do hereby acknowledge that all information on this form is true and factual.

Patient Signature:____ Date:_________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION OF RELEASE OF SPECIFIC INFORMATION

Patient Name:____ Clinic:____________________________________

MVP Physical Therapy reserves the right to modify the privacy practices outlined in this notice.

I acknowledge that I have received or have had the opportunity to receive a copy of the official Notice of Privacy Practices from MVP Physical Therapy, Inc.

Signature:____ Date:_____________________________

(PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE)

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Legal Guardian

Initial all statements that apply:

________ I authorize you to leave messages regarding my appointments on my answering machine or voicemail as listed on my patient information.

________ I authorize you to discuss my appointments with my spouse as listed on my patient information.

________ In addition to my referring doctor, I authorize you to communicate with and send reports & evaluations to the following:

____

____

By signing this authorization, I understand that this does not authorize release of medical information by MVP Physical Therapy, Inc. to any other organization or agency unless I grant further authorization. I also understand that these authorizations may be revoked at anytime.

Signature:____ Date:_____________________________

(PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE)

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Legal Guardian

HEALTH HISTORY

Patient Name:____ Height____Weight_____ Date of Birth___/___/__

CURRENT COMPLAINTS

How and when did your injury/condition/surgery begin?____

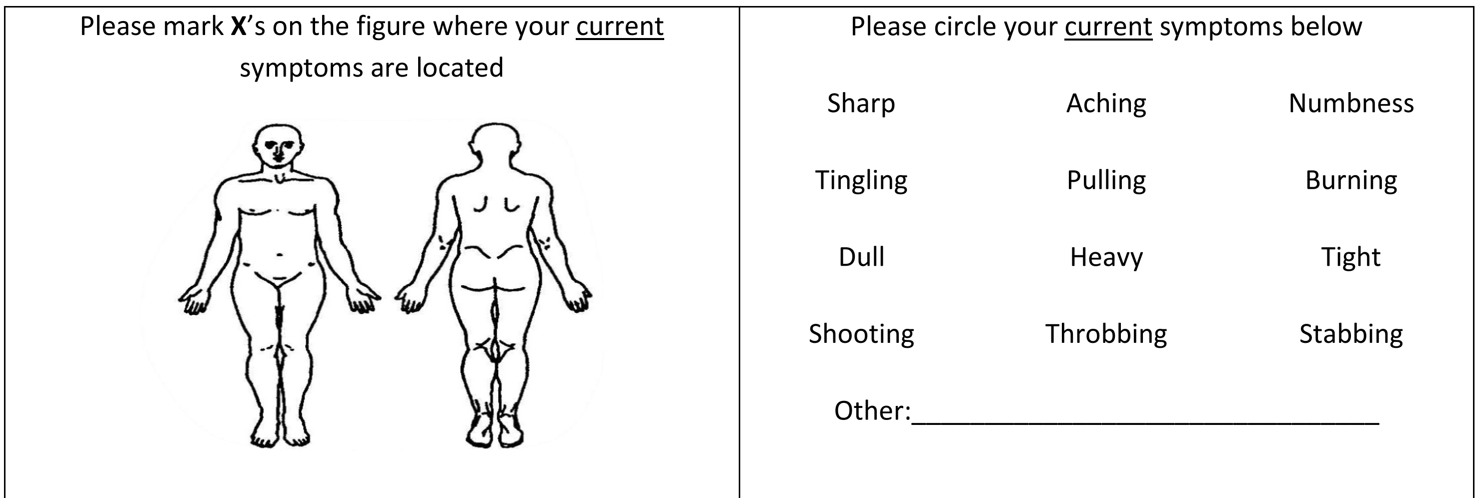
What makes your pain increase?____

What makes your pain decrease?____

How long does it take for your pain to subside?____

Have you ever had a similar injury/condition in the past?____

Is your injury/condition **getting better**, **staying the same**, or **getting worse**? (Circle one)



Please mark **X**'s on the figure where your current symptoms are located

Please circle your current symptoms below

Sharp	Aching	Numbness
Tingling	Pulling	Burning
Dull	Heavy	Tight
Shooting	Throbbing	Stabbing

Other:__________________________________

Rate your pain level over the last week at its best and at its worst on the scale below

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 **UNBEARABLE PAIN**

On the percentage scale below, circle your current level of overall function

NO RESTRICTIONS 100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0% **UNABLE TO FUNCTION**

Are you currently working?	YES	NO
Do you have any work restrictions?	YES	NO

Please specify any work restrictions given to you by your doctor

____

____

Please list any specific limitations you have due to your current symptoms

At Home: ____

At Work: ____

At Leisure: ____

MEDICAL HISTORY

Condition	Response	Condition	Response	Condition	Response
Allergies	☐Yes ☐No	Dizzy Spells	☐Yes ☐No	Metal Implants	☐Yes ☐No
Anemia	☐Yes ☐No	Emphysema/Bronchitis	☐Yes ☐No	MRSA	☐Yes ☐No
Anxiety	☐Yes ☐No	Fractures	☐Yes ☐No	Multiple Sclerosis	☐Yes ☐No
Arthritis	☐Yes ☐No	Fibromyalgia	☐Yes ☐No	Muscular Disease	☐Yes ☐No
Asthma	☐Yes ☐No	Gallbladder Problems	☐Yes ☐No	Osteoporosis	☐Yes ☐No
Auto Immune Disease	☐Yes ☐No	Headaches	☐Yes ☐No	Parkinsons	☐Yes ☐No
Cancer	☐Yes ☐No	Hearing Impairment	☐Yes ☐No	Rheumatoid Arthritis	☐Yes ☐No
Cardiac Conditions	☐Yes ☐No	Hepatitis	☐Yes ☐No	Seizures	☐Yes ☐No
Cardiac Pacemaker	☐Yes ☐No	High Cholesterol	☐Yes ☐No	Smoking	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Speech Problems	☐Yes ☐No
Circulation Problems	☐Yes ☐No	HIV/AIDS	☐Yes ☐No	Strokes	☐Yes ☐No
Currently Pregnant	☐Yes ☐No	Incontinence	☐Yes ☐No	Thyroid Disease	☐Yes ☐No
Depression	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Diabetes	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Vision Problems	☐Yes ☐No

Describe any other conditions or precautions:

FALL HISTORY

Injury as a result of a fall in the past year? ☐ Yes ☐ No Date of Fall:_______________________________________

Two or more falls in the last year? ☐ Yes ☐ No Dates of Falls:_____________________________________

SURGICAL HISTORY

Body Region:_____________________ Surgery Type:_____________________ Date of Surgery:___________________

Body Region:_____________________ Surgery Type:_____________________ Date of Surgery:___________________

Body Region:_____________________ Surgery Type:_____________________ Date of Surgery:___________________

Body Region:_____________________ Surgery Type:_____________________ Date of Surgery:___________________

CURRENT MEDICATIONS

Drug:_____________________________ Dosage:________________ Reason for Taking:__________________________

Drug:_____________________________ Dosage:________________ Reason for Taking:__________________________

Drug:_____________________________ Dosage:________________ Reason for Taking:__________________________

Drug:_____________________________ Dosage:________________ Reason for Taking:__________________________