



[] West Los Angeles [] Westlake Village [] Simi Valley

PATIENT INFORMATION:

Name: _____ Date of Birth: _____ Age: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone-Home: () _____-_____ Work: () _____-_____ Mobile: () _____-_____

E-mail: _____ Want a Visit Reminder? Email or Text:

Social Security No.: _____-_____-_____ Male Female Referring Physician: _____

Employer/School: _____ Occupation/Sport: _____

Have you provided Athletic PT with your current primary and secondary health insurance information? Yes No

SPOUSE OR PARENT/GUARDIAN: N/A

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Business Phone: () _____-_____

IN CASE OF AN EMERGENCY, WHOM MAY WE CONTACT?

Name: _____ Phone: () _____-_____

INJURY HISTORY:

How did the injury/symptoms occur? _____

When did the injury or symptoms first appear? _____

What are your current symptoms (pain/burning/numbness ache) and where are they on your body? _____

What is your average daily pain over the past week 1-10? (0 is none and 10 is severe) _____

Did you have x-rays/MRI/CT scan of this body part and what were the findings? _____

Have you had surgery for this condition and when? _____

Patient's Signature: _____ Date: ____/____/____



Patient/Responsible Party Name: _____

Assignment of Benefits

_____ (initial) I hereby authorize, Athletic Physical Therapy, Inc. / Get Fit Physical Therapy, Inc. / Stephen Clark, DPT, OCS, to furnish to my insurance carrier(s) any and all requested information concerning my health care. I also authorize my insurance carrier(s) to pay Athletic Physical Therapy Inc. / Get Fit Physical Therapy, Inc. / Stephen Clark, DPT, OCS, directly for services rendered.

Cancellation/No Show Policy

_____ (initial) There will be a \$45 charge directly to the patient for all appointments that are not cancelled 24 hours BEFORE the scheduled appointment time or if the patient does not show up for their appointment "no show". More than 3 no shows or cancellations and you may be placed on a "call list" for same day appointment only no advanced scheduling. Call the office directly to cancel your appointment -text and emails are not accepted. Cancellation fees are NOT covered by insurance. Fees are paid by the patient.

Notice of Privacy Policies

_____ (initial) I have received/reviewed a copy of Athletic Physical Therapy, Inc /Get Fit Physical Therapy, Inc Health Information Privacy Policies.

Consent to Treatment

_____ (initial) I give consent for Athletic Physical Therapy, Inc /Get Fit Physical Therapy, Inc to treat my condition within the scope of practice defined by the American Physical Therapy Association Practice Act and the Licensing Board of the Department of Consumer Affairs. Treatment is administered based on the physician's diagnosis and requires a prescription throughout the plan of care. It is my responsibility to provide Athletic Physical Therapy, Inc /Get Fit Physical Therapy, Inc with these prescriptions as needed. I also understand that if I wish to stop treatment at any time for any reason, I must simply tell my therapist to stop or adjust treatment to my preference. If I have any complaints about the treatment I am receiving, I should ask and will receive the contact information for the Clinical Director, Stephen Clark, PT, DPT, OCS.

Payment for Services

_____ (initial) Private pay, co-payment, co-insurance and/or deductible payments are required each treatment. It is my responsibility to make these payments in order for me to continue with my treatments. I understand that every attempt will be made by Athletic Physical Therapy, Inc /Get Fit Physical Therapy, Inc to collect the proper amount however I understand that I may receive an additional bill in the event that my insurance company does not process claims in the same manner as was quoted to Athletic Physical Therapy, Inc /Get Fit Physical Therapy, Inc. I also agree that anything an Athletic Physical Therapy, Inc /Get Fit Physical Therapy, Inc employee or representative says about my health insurance benefits is speculation and it is my responsibility to check what benefits are available for services.

Help Us Share the Knowledge

_____ (initial) I grant permission to Athletic Physical Therapy, Inc for the use of photograph(s) or electronic media images/videos as identified below in any presentation of any and all kind whatsoever. I understand that I may revoke this authorization at any time by notifying any Athletic Physical Therapy, Inc employees in writing. Images will be solely used for educational purposes and handled by authorized staff

or _____ (initial) I respectfully decline the use of my photographs/videos.

Signature: _____

Date: _____



General Health Questionnaire

Do you currently experience any of these symptoms?

- 1. Fevers/Chills/sweats _____ Yes _____ No
- 2. Unexplained weight loss/gain _____ Yes _____ No
- 3. Malaise (feeling generally unwell) _____ Yes _____ No
- 4. Unusual fatigue _____ Yes _____ No
- 5. Nausea/Vomiting _____ Yes _____ No
- 6. Numbness/tingling _____ Yes _____ No
- 7. Weakness _____ Yes _____ No

- 8. Dizziness/lightheadedness/loss of consciousness _____ Yes _____ No
- 9. Chest pain/palpitations _____ Yes _____ No
- 10. Swelling in feet or hands _____ Yes _____ No
- 11. Difficulty breathing/shortness of breath _____ Yes _____ No
- 12. Difficulty breathing when lying down _____ Yes _____ No
- 13. Cough/change in cough/blood in phlegm _____ Yes _____ No
- 14. Wheezing _____ Yes _____ No

- 15. Difficulty with swallowing _____ Yes _____ No
- 16. Heartburn/Indigestion _____ Yes _____ No
- 17. Change in appetite _____ Yes _____ No
- 18. Specific food intolerance/nausea/vomiting _____ Yes _____ No
- 19. Bowel pattern changes (color, texture, frequency) _____ Yes _____ No

- 20. Difficulty urinating (starting/stopping) _____ Yes _____ No
- 21. Urine frequency changes _____ Yes _____ No

Do you have any other medical issues or previous medical conditions not mentioned above?

Please list your current medications: _____

Are you allergic to any medications (cortisone/menthol)? _____

What medical conditions exist in your parents' (birth mother and father) medical history?

Please Print Your Name: _____