# BODY REBUILDERS
## PHYSICAL THERAPY

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**Confidential Medical History/Evaluation:** Date: ____/____/___ Referring MD: _____

Name: _____ DOB: ___/___/____ Height/Weight: _____

Address: _____ Phone (Home): _____

_____ Phone (Cell): _____

Insurance Company: _____ Subscriber ID: _____ SS#: _____

Insured Employer/Address: _____ Phone: _____

Occupation: _____ Is this injury? Work related _____ Auto Accident _____

Chief Complaint: _____ Date of Injury: _____

Current Symptoms: Pain Numbness Stiffness Weakness Condition: New Acute Chronic

List any/all medications you are currently taking: _____

List any surgeries:_____

Have you had any Diagnostic or Rehabilitative Services for this Injury? MRI X-rays Other:

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**Do you have any of the following?**

| | YES | NO |
|---|---|---|
| Asthma, bronchitis or emphysema | | |
| Shortness of Breath/Chest Pain | | |
| Coronary Heart Disease | | |
| Do you have a Pacemaker | | |
| High Blood Pressure | | |
| Heart Attack / Surgery | | |
| Stroke / TIA | | |
| Blood Clot / Emboli | | |
| Epilepsy / Seizures | | |
| Thyroid Trouble / Goiter | | |
| Anemia | | |
| Infectious Diseases | | |
| Diabetes | | |
| Cancer or Chemo / Radiation | | |
| Arthritis / Swollen Joints | | |
| Osteoporosis | | |
| Varicose Veins | | |
| Gout | | |
| Sleeping Difficulties | | |
| Emotional/psychological problems | | |
| Bowel or Bladder Problems | | |
| Severe/Frequent Headaches | | |
| Vision/ Hearing Difficulties | | |
| Dizziness or Faintness | | |

**Pain when performing the following activities?**

| | Mild | Moderate | Severe | Unable |
|---|---|---|---|---|
| Bending | | | | |
| Care for Infirm Family | | | | |
| Carrying Groceries | | | | |
| Change Position (sit to stand) | | | | |
| Climb Stairs | | | | |
| Driving | | | | |
| Extended Computer Use | | | | |
| Feeding (Self) | | | | |
| Household Chores | | | | |
| Kneeling | | | | |
| Lift Children | | | | |
| Lift | | | | |
| Pet Care | | | | |
| Reading (Concentration) | | | | |
| Self-Care-Bathing | | | | |
| Self-Care- Dressing | | | | |
| Sexual Activities | | | | |
| Sleep | | | | |
| Sitting (Prolonged) | | | | |
| Standing (Prolonged) | | | | |
| Walking | | | | |
| Yard Work | | | | |
| Recreational Activities | | | | |
| Sports | | | | |

Smoking: Daily _____ Weekly _____ Alcohol Consumption: Daily_____ Weekly _____ Exercise: Daily _____ Weekly _____

Other Medical Conditions: _____

Please mark the location of your symptom(s).

Please Rate Your Pain:

(0= No pain, 1= Minimal, 10= Severe)

At present:

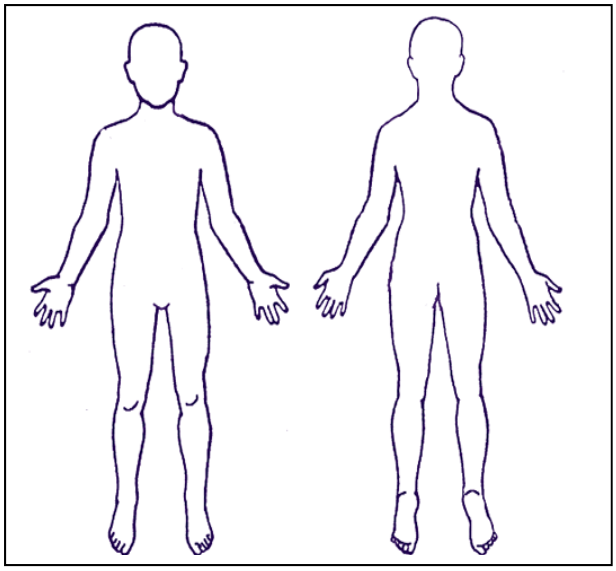
0 1 2 3 4 5 6 7 8 9 10

At its worst:

0 1 2 3 4 5 6 7 8 9 10

At its best:

0 1 2 3 4 5 6 7 8 9 10



Consent for treatment:

I hereby agree and give my consent to treatment procedures and patient care which in the judgement of my therapist and/or physician, may be considered necessary or advisable while I am a patient of Body Rebuilders.

Cancellation and Attendance Policy:

We are committed to your rehabilitation. In order to meet your rehabilitation goals, it is extremely important that you attend your physical therapy appointments as recommended by your therapist and physician. In an event you cannot attend a scheduled appointment, we ask that you call 24 hours in advance. If you cancel within 24 hours of your appointment, this is considered a late cancel and we will charge a $25 dollar fee for a single appointment, $50 for a double slot. Cancellations fees are not billable to your insurance and must be paid prior to your next appointment. We reserve the right to discontinue care after 3 missed appointments.

Assignment of Insurance Benefits/ Guarantee of Account:

I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes of personal or insurance information that may occur. I authorize release of payment directly to Body Rebuilders regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

By signing below, I acknowledge I have read, understand, and agree to all the policies listed above.

_____ _____

Patient Name (please print) Date

_____ _____

Patient/Patient Representative Signature Name of Representative/Relationship to Patient