Yarrington
Physical Therapy & Sports Care, Inc.

We would like to thank you for the opportunity to partner with you in your recovery.

PATIENT INFORMATION

NAME (Last, First Middle)	BIRTH DATE	SSN	SEX

LOCAL ADDRESS	CITY, STATE ZIP

PRIMARY PHONE	EMAIL ADDRESS	EMERGENCY CONTACT NAME AND PHONE NUMBER
SECONDARY PHONE	**EMPLOYER / JOB TITLE**	

CASE INFORMATION

REFERRING PHYSICIAN	FAMILY PHYSICIAN	STATUS
		☐ MARRIED ☐ SINGLE ☐ FULL TIME STUDENT ☐ PART TIME STUDENT ☐ EMPLOYED ☐ OTHER
CONDITION RELATED TO ☐ EMPLOYMENT ☐ AUTO ACCIDENT ☐ OTHER _____		
DATES UNABLE TO WORK (MM/DD/YY) ____/____/____ TO ___/____/____	**DATES OF HOSPITALIZATION (MM/DD/YY)** ____/____/____ TO ____/____/____	
DATE OF INJURY	**DATE PROBLEM(S) BEGAN**	**DATE OF SURGERY**

PAST MEDICAL HISTORY

PAST MEDICAL HISTORY: Have you or an immediate family member ever been told you have:

	YES	NO		YES	NO		YES	NO
ANEMIA / BLOOD DISEASE			DIABETES			HIGH BLOOD PRESSURE		
BONE / JOINT PROBLEM			DIZZINESS / FAINTING			LUNG DISEASE		
ARTHRITIS / RHEUMATISM			EPILEPSY / SEIZURES			PARALYSIS		
ALLERGIES			FIBROMYALGIA			PREGNANCY (CURRENT)		
BACK TROUBLE			HEADACHES			SKIN PROBLEMS		
BREATHING PROBLEMS			HEAD / SPINAL INJURY			STROKE		
BROKEN BONES			HEART ATTACK			SWELLING OF LEG OR JOINTS		
CANCER OR TUMOR			HERNIA			ANXIETY / PANIC ATTACKS		
ANGINA OR CHEST PAIN			CHEMICAL DEPENDENCY (ALCOHOL / DRUGS)			CIRRHOSIS / LIVER DISEASE		
DEPRESSION			EATING DISORDER (BULIMIA / ANOREXIA)			HEMOPHILIA / SLOW HEALING		
HIGH CHOLESTEROL			KIDNEY DISEASE / STONES			MULTIPLE SCLEROSIS		
OSTEOPOROSIS			TUBERCULOSIS			PACEMAKER		
PARKINSON'S DISEASE			INFECTION			GOUT		
PROSTATE PROBLEMS			THYROID PROBLEMS			STOMACH PROBLEMS		

GENERAL HEALTH			
1.	I would rate my health as (circle one): Excellent Good Fair Poor		
2.	Are you taking any prescription or over-the-counter medications? If yes, please list:	YES	NO
3.	Are you taking any nutritional supplements?	YES	NO
4.	Have you had any illnesses within the last 3 weeks (example: cold, flu, infection)? If yes, have you had this problem before in the last 3 months?	YES YES	NO NO
5.	Have you noticed any lumps or thickening of the skin or muscle anywhere on your body?	YES	NO
6.	Do you have any sores that have not healed or any changes in size, shape, or color of a wart or mole?	YES	NO
7.	Have you had any unexplained weight gain or loss in the last month?	YES	NO
8.	Do you smoke or use tobacco? If yes, how many packs per day? How many years or months?	YES	NO
9.	I used to smoke or use tobacco but I quit. If yes: pack or amount per day_____ Year quit_____	YES	NO
10.	I would like to quit smoking or using tobacco?	YES	NO
11.	How much alcohol do you drink in the course of a week? (one drink is equal to 1 beer, 1 glass of wine, or 1 shot of hard liquor)_____		
12.	Do you use recreational or street drugs? If yes, what, how much, how often? _____	YES	NO
13.	How much caffeine do you consume daily (including soft drinks, coffee, tea, sweet tea, or chocolate?		
14.	Are you on any special diet?	YES	NO
15.	Do you have (or have you recently had) any of the following problems		

√		√		√	
	Blood in urine, stool, vomit, mucous		Cough		Difficulty swallowing or speaking
	Dizziness, fainting, blackouts		Dribbling or leaking urine		Memory Loss
	Fever, chills, sweats		Heart palpitations or fluttering		Confusion
	Nausea, vomiting, loss of appetite		Numbness or tingling		Sudden weakness
	Changes in bowel or bladder		Swelling or lumps		Trouble sleeping
	Throbbing sensation / pain in the belly or anywhere else		Problems seeing or hearing		Lack of coordination or falling
	Skin rash or other changes		Unusual fatigue, drowsiness		None of these

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MEDICAL / SURGICAL HISTORY			
1.	**Have you ever been treated with chemotherapy, radiation therapy, biotherapy, or radiation implants?** **If yes, please describe:**	**YES**	**NO**
2.	**Have you had any x-rays, sonograms, CT scans, MRI, or other imaging tests done recently?** **If yes, what? When? Results (if known)?**	**YES**	**NO**
3.	**Have you had any laboratory work done recently (urinalysis or blood tests)?** **If yes, what? When? Results (if known)?**	**YES**	**NO**
4.	**Any other clinical tests?** **Please describe:**	**YES**	**NO**
5.	**Please list any operations you have ever had and the date(s):** **Operation** **Date**		
6.	**Do you have a transplanted organ, joint replacement, breast implants, or any other implants / devices?** **If yes, please describe:**	**YES**	**NO**

WORK / LIVING ENVIRONMENT

1. **What is your job or occupation? _____**
2. **Does your work involve:**

- ○ **Prolonged sitting**
- ○ **Prolonged standing**
- ○ **Prolonged walking**
- ○ **Use of large or small equipment**
- ○ **Lifting, bending, twisting, climbing, turning**
- ○ **Exposure to chemicals, pesticides, toxins, or gases**
- ○ **Other, please describe**
- ○ **None of these apply**

History of Falls

- ○ **In the past year, I have had no falls**
- ○ **I have just started to lose my balance / fall**
- ○ **I fall occasionally**
- ○ **I fall frequently (more than two times during the past 6 months)**
- ○ **Certain factors make me cautious (curbs, ice, stairs, getting into or out of the tub**

I live

- ○ **Alone**
- ○ **With family, spouse, partner**
- ○ **Assisted Living**
- ○ **Other**

CONSENT FOR TREATMENT

I, the undersigned, a patient at Yarrington Physical Therapy & Sports Care, Inc., do hereby authorize the clinic's employed physical therapists and whoever they may designate as their assistant to administer treatment as is necessary. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that as a courtesy Yarrington Physical Therapy & Sports Care, Inc. will prepare insurance forms and bill my insurance company directly. I hereby request assignment of payment of all insurance benefits to Yarrington Physical Therapy & Sports Care, Inc. I am ultimately responsible for payment of all services rendered, unless otherwise provided by law.

DEDUCTIBLES/PERCENTAGE PAYS AND/OR CO-PAYMENTS

Co-payments are to be paid at time of service, unless prior arrangements have been made with Yarrington Physical Therapy & Sports Care, Inc. Deductible and percentage payment amounts will be billed at the time the payment from your insurance company is received. Payment is due within 30 days of the date on the invoice. Patients agree to make every effort to keep payments current.

MEDICARE/MEDICAID PATIENTS

I understand Yarrington Physical Therapy & Sports Care, Inc. does not file with Medicaid as a secondary insurance. I have been informed that I am responsible for remaining balance after Medicare has paid as my primary insurance.

CANCELLATION/NO-SHOW POLICY

I understand that cancellations should be made within 24 hours prior of their scheduled time, unless extenuating circumstances prevent otherwise. I understand that three no-shows will result in my discharge from physical therapy. **By signing this consent I understand that I will be charged $25.00 per no-show appointment after my first no-show**. There is no charge for cancelling, but excessive cancelations may result in your discharge from physical therapy; this will be evaluated on a case by case basis.

NOTICE OF PATIENT INFORMATION PRACTICES

I confirm that I have **(PLEASE CIRCLE)** RECEIVED OR DECLINED a copy of Yarrington Physical Therapy & Sports Care, Inc.'s Notice Of Patient Information Practices.

I have read and fully understand Yarrington Physical Therapy & Sports Care, Inc.'s Notice of Information Practices. I understand that Yarrington Physical Therapy & Sports Care, Inc. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Yarrington Physical Therapy & Sports Care, Inc. will consider requests for restriction on a case by case basis, but is not bound by law to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Yarrington Physical Therapy & Sports Care, Inc.'s Notice of Information Practices. I understand that I have the right to revoke this consent by notifying the practice in writing at any time.

_____ _____

Patient or Legal Guardian's Signature **Date**