WholeBody Wellness and Physical Therapy, llc

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Office (860) 430-9122
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Carol Gordon, PT, IMT,C

CT License #2520 *NPI # 1366581738* *EIN 47-1106892*

Patient Information:

Patient Name: _____ Date of Birth: ____/____/____ Date of Evaluation: ____/____/____

Single☐ Married☐ Divorced☐ Separated☐ Widowed☐ Partnered☐

Street Address:_____

City: _____ State:☐ Zip Code: _____ Country: _____

Home Phone: (____) ____-_____ Work: (____) ____-_____ Cell: (____) ____-_____

Email Address: _____

If Child, Parent/Guardian's Name: _____

Employer: _____ Occupation: _____

Work Address: _____

Referring Physician: _____Phone: (____) ____-_____

Physician Address: _____

In case of emergency, please list best contact information:

Name: _____ Phone: (____) ____-_____ Relationship: _____

Insurance Information:

Are you submitting to insurance? Yes☐ No☐

If yes, please provide your insurance information below:

Insurance carrier: _____ ID Number: _____

Policy Holder: _____

Policy Holder's date of birth: (____) ____-_____

Chief Complaint(s) / Diagnosis:

Please share with us your chief complaint(s) / diagnosis that brought you here today:

1. _____

2. _____

3. _____

4. Was it because of a: Motor vehicle accident? Yes ☐ No ☐

   Work-related injury? Yes ☐ No ☐

   Fall? Yes ☐ No ☐

When did your current pain / problem begin? _____

Past Medical History: (Include all surgeries and traumas)

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Medications:

Please list your current medications, over the counter medications and/or supplements you are taking:

Current Medications or Supplements	Dosage	For How Long?	List All Medications or Supplements you have taken over the Last 5 Years

Attach a piece of paper if necessary

Pain/Symptoms:

Location of pain / symptoms: _____

_____

_____

Pain Level (0-10): Now ____ Best ____ Worst ____

Is the pain (please circle one): Constant / Intermittent / Improving / Worsening / Not Changing

What makes pain/symptoms worse? _____

What makes pain/symptoms better? _____

Please tell us about any areas of your body where you feel numbness, pins and needles, and burning:

_____

Work:

Occupation/job requirements: _____

When did you last go to work? _____

Function:

Current Exercise: (Check all that apply)

- ☐ 5-7 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ Infrequent
- ☐ Never
- ☐ 45 minutes or more duration per workout
- ☐ 30-45 minutes duration per workout
- Less than 30 minutes

- ☐ Walk
- ☐ Swim
- ☐ Run, Jog, Jump Rope
- ☐ Yoga
- ☐ Other:_____
- ☐ Other:_____

Previous Level of Exercise: (Check all that apply)

- ☐ 5-7 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ Infrequent
- ☐ Never
- ☐ 45 minutes or more duration per workout
- ☐ 30-45 minutes duration per workout
- ☐ Less than 30 minutes

- ☐ Walk
- ☐ Swim
- ☐ Run, Jog, Jump Rope
- ☐ Yoga

- ☐ Other: _____
- ☐ Other: _____

Activities of daily living are compromised as follows:

Bed Activities:	☐	Lying on stomach is	☐ Painful	☐ Difficult	☐ Not Possible
	☐	Lying on back is	☐ Painful	☐ Difficult	☐ Not Possible
	☐	Lying on Right side is	☐ Painful	☐ Difficult	☐ Not Possible
	☐	Lying on Left side is	☐ Painful	☐ Difficult	☐ Not Possible
	☐	Rolling over in bed is	☐ Painful	☐ Difficult	☐ Not Possible
Transfer Activities	☐	Lying to sit is	☐ Painful	☐ Difficult	☐ Not Possible
	☐	Sit to lying is	☐ Painful	☐ Difficult	☐ Not Possible
	☐	Sit to Stand is	☐ Painful	☐ Difficult	☐ Not Possible

Standing is: ☐ Painful ☐ Difficult ☐ Not Possible

Present COMFORTABLE standing tolerance: _____min/hrs

Sitting is: ☐ Painful ☐ Difficult ☐ Not Possible

Present COMFORTABLE sitting tolerance: _____min/hrs

Driving is: ☐ Painful ☐ Difficult ☐ Not Possible

Present COMFORTABLE driving tolerance: _____min/hrs

Sitting in a car is: ☐ Painful ☐ Difficult ☐ Not Possible

Present COMFORTABLE sitting in a car tolerance: _____min/hrs

Walking is: ☐ Painful ☐ Difficult ☐ Not Possible

Present COMFORTABLE walking tolerance: _____min/hrs

Running is: ☐ Painful ☐ Difficult ☐ Not Possible

Present COMFORTABLE running tolerance: _____min/hrs

Work is: ☐ Painful ☐ Difficult ☐ Not Possible

Present COMFORTABLE work tolerance: _____min/hrs

Stairs are: ☐ Painful ☐ Difficult ☐ Not Possible

Bending and lifting activities are: ☐ Painful ☐ Difficult ☐ Not Possible

Reaching activities are: ☐ Painful ☐ Difficult ☐ Not Possible

Sports and leisure activities are: ☐ Painful ☐ Difficult ☐ Not Possible

Other:_____ ☐ Painful ☐ Difficult ☐ Not Possible

☐ All activities are performed despite ☐ Pain ☐ Fatigue ☐ Lack of energy

Current Assistive Devices:

Cane	☐ Yes	☐ No
Walker	☐ Yes	☐ No
Manual Wheelchair	☐ Yes	☐ No
Motorized Wheelchair	☐ Yes	☐ No
Corrective Lenses/Glasses	☐ Yes	☐ No
Hearing Aids	☐ Yes	☐ No
Dentures	☐ Yes	☐ No
Prosthetics	☐ Yes	☐ No
Shunts	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Insulin Pump	☐ Yes	☐ No
Baclofen Pump	☐ Yes	☐ No
Other:		

Present Home Environment:

Stairs	☐ Yes	☐ No
Stairs, railing	☐ Yes	☐ No
Ramps	☐ Yes	☐ No
Elevator	☐ Yes	☐ No
Uneven Terrain	☐ Yes	☐ No
Bathroom modifications	☐ Yes	☐ No
Any other obstacles:	☐ Yes	☐ No

Current Health Habits:

- ☐ Tobacco: Cigarettes #/day ____ Cigars #/day ____ Pipe ____ Chewing ____
- ☐ Alcohol: Wine or beer #glasses/day or wk ____ Liquor # ounces/day or wk ____
- ☐ Caffeine: Coffee: #6 oz cups/day ____ Tea: #6 oz cups/day ____
- ☐ Soda w/caffeine: # cans/day ____ Diet Sodas #cans/day ____
- ☐ Other: _____

Nutrition and Diet:

- ☐ Gluten Free Diet
- ☐ Salt Restriction
- ☐ Low Fat Diet
- ☐ Low Carbohydrate Diet
- ☐ Vegetarian / Vegan
- ☐ Paleo Diet
- ☐ Other: _____

Specific Food Restrictions:

☐ Dairy ☐ Eggs ☐ Soy ☐ Corn ☐ Gluten ☐ Wheat ☐ Sugar

Other: _____

Current / New Goals for Therapy:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Other Comments / Concerns

1. _____
2. _____
3. _____

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA):

I, (print) _____ , hereby acknowledge that I received a copy of the Notice of Privacy
(Patient/Parent/Guardian)
Practices. I further acknowledge that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Patient Name (print): _____ Date: ____/____/____
Signature: _____ Relationship to Patient: _____

Financial Policy:

Please read and initial:
____ WholeBody Wellness and Physical Therapy, llc. does not participate with private insurance carriers. It is our policy to collect payment at time of service. Patients are financially and legally responsible for charges incurred. We accept Checks, Cash, Direct Debit, Visa, MasterCard, American Express, and Discover.

Cancellations and Missed Appointments:

Please read and initial:

____ Patients are responsible for all appointments they have scheduled. Patients who choose not to attend or call to cancel their appointments are still responsible for these appointment times. Fees for missed appointments and/or late cancellations are expected at or before the patient's next scheduled appointment. Insurance does not cover these fees. Any patient who misses more than two appointments, without sufficient notice of cancellation during his or her course of treatment, may be required to prepay for scheduled sessions. Any exceptional circumstances must be submitted to our Practice Manager for review.

____ **24 HOURS NOTICE IS REQUIRED TO CANCEL EACH ONE HOUR APPOINTMENT YOU HAVE SCHEDULED.** (Example: 2 hours scheduled = 48 hours (2 days) notice; 3 hours scheduled = 72 hours (3 days) notice, etc.)

____ **FOR ANY LATE CANCELLATION OR MISSED APPOINTMENT, THE CHARGE WILL BE AS FOLLOWS:**
$100.00 for each hour

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Authorization for Release of Records:

Please read and initial:

I authorize WholeBody Wellness and Physical Therapy, llc. to release pertinent clinical and account information to the following **insurance companies and/or healthcare providers** to facilitate my reimbursement and/or to facilitate my clinical well-being and coordination of care:

1. _____

2. _____

3. _____

4. _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____