BACK IN ACTION
PHYSICAL THERAPY

Patient Demographics

Name:_____ **Date of Birth (mm/dd/yyyy)**:_____

Parent/Guardian (if patient is <18 yrs):_____

Address:_____

Phone (H):_____ **(W):**_____ **(C):**_____

Email address:_____

In case of emergency, please contact:_____

Primary Ins Holder/ Responsible Party (If different from above):

Name:_____ **DOB:**_____ **Relation:** Choose

Release of Medical Information

Initial

☐ I authorize Back In Action to release my medical information regarding this injury or condition to my referring provider. I authorize my referring provider to send information regarding this injury or condition to Back In Action as necessary.

☐ I authorize Back In Action to file insurance and accept assignment of benefits on my behalf and authorize Back In Action to release my medical information regarding this injury or condition to my health insurance company (or Worker's Compensation company) as necessary for reimbursement purposes.

☐ I authorize Back In Action to release my medical information regarding this injury or condition to _____

☐ I have been made aware of the privacy policy held by Back In Action and understand that I may request a copy at any time.

Back In Action Physical Therapy
Cancellation / No-Show Policy

Because we *only schedule one patient per hour*, it is important that our patients show up for their scheduled visit. Please be considerate of those who are waiting for an appointment slot to open and give at least 24 hours notice if cancelling a scheduled appointment.

Please help us to continue providing high quality care by attending your scheduled visits. We ask for your commitment as we make your health our commitment.

Our policy is not to charge for missed appointments. Rather, our policy is to discharge our patient from further care after 3 or more missed appointments.

☐ I have read and understand Back In Action's Cancellation/No-show Policy.

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Authorization for Physical Therapy Evaluation and Treatment

I consent and agree to actively participate in a physical therapy assessment and subsequent treatments, personal care and therapeutic exercises or activities prescribed by Back In Action physical therapists. I understand that physical therapy is meant to restore movement and function with as little pain or discomfort as possible and therefore understand that physical activity is an integral part of this treatment process**.**

Name: _____ **Date** _____
(**Electronically signed)**

Back In Action Physical Therapy
Medical History and Review of Systems

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Name: _____
Age: _____ **Height:** _____ **Weight:** _____
Occupation / Sports / Leisure Activities: _____

Reason for visit: _____
Date of injury / onset: _____
How did this occur? _____

Current Medications: _____

Do you have/ Have you had:

Cancer?	☐ Yes	☐ No	_____
Diabetes?	☐ Yes	☐ No	_____
High Blood Pressure?	☐ Yes	☐ No	_____
Heart Disease?	☐ Yes	☐ No	_____
Osteoporosis?	☐ Yes	☐ No	_____
Osteoarthritis?	☐ Yes	☐ No	_____
Rheumatoid/Psoriatic Arthritis?	☐ Yes	☐ No	_____
Neurologic Disease (MS, Parkinsons)?	☐ Yes	☐ No	_____
Ulcers/ GERD/ Acid Reflux?	☐ Yes	☐ No	_____
Kidney/ Liver Disease?	☐ Yes	☐ No	_____
Prior Surgeries?	☐ Yes	☐ No	_____
Allergies?	☐ Yes	☐ No	_____

Other: _____

In the past 3 months, have you experienced:

Change in your general health?	☐ Yes	☐ No	_____
Fever/ Chills/ Sweats?	☐ Yes	☐ No	_____
Unexplained weight loss/gain >10lbs?	☐ Yes	☐ No	_____
Numbness or tingling?	☐ Yes	☐ No	_____
Bowel/ Bladder Incontinence?	☐ Yes	☐ No	_____
Difficulty sleeping due to pain?	☐ Yes	☐ No	_____
Unexplained Falls/ Decreased Balance?	☐ Yes	☐ No	_____

Back In Action Physical Therapy
Medical History and Review of Systems

Are You:

Pregnant/ Potentially Pregnant/ Nursing? ☐ Yes ☐ No _____
Depressed? ☐ Yes ☐ No _____
A tobacco user? ☐ Yes ☐ No _____

Please check any symptoms you currently have:

Constitution
- ☐ Fever/Chills
- ☐ Weight loss

Eyes
- ☐ Change in eyesight
- ☐ Dry eyes
- ☐ Drainage from eyes

ENT
- ☐ Hearing changes
- ☐ Ear ache
- ☐ Nose bleeds
- ☐ Sore throat
- ☐ Hoarseness

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations
- ☐ Fast/slow pulse
- ☐ Fainting Spells
- ☐ Leg pain w/ exercise
- ☐ Leg/ankle swelling
- ☐ Shortness of breath

Respiratory
- ☐ Coughing
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Snoring

GI
- ☐ Abdominal Pain
- ☐ Nausea/ vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Blood in stool

Genitourinary
- ☐ Pain with urination
- ☐ Incontinence

Skin
- ☐ Skin lesions
- ☐ Rash
- ☐ Itching/burning
- ☐ Unusual growth

Musculoskeletal
- ☐ Neck/backpain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Joint stiffness

Neurologic
- ☐ Numbness
- ☐ Tingling
- ☐ Dizziness/Falls
- ☐ Fainting
- ☐ Headaches
- ☐ Weakness

Endocrine
- ☐ Droopy eyelids
- ☐ Hot flashes
- ☐ Fatigue
- ☐ Voice changes

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PHYSICAL THERAPY

Any additional information: _____