NEW PATIENT INFORMATION

Please print clearly

Name: (First)_____ (Last)_____ (M.I.)_____

Address: _____

City_____ State_____ Zip_____ Date of Birth:_____ Sex: M / F

Home Phone: _____ Cell Phone: _____ Email: _____

Emergency Contact:_____Phone:_____Relationship: _____

Referring/Primary Care Physician: _____Phone: _____

Social: Married / Single / Divorced / Separated / Widowed Have you been hospitalized in the past 60 days? Y / N

Employment: Full-Time / Part-Time / None / Retired / Student Employer: _____

Have you had ***physical therapy/ occupational therapy/chiropractic treatment*** this calendar YEAR? Y / N

If Yes, where? _____ Number of Visits: _____

How did you hear about us? *Patient Friend/Family Referring MD Social Media Internet Search Location/Signage Community Event Employer/Insurance Other:*_____

PAST MEDICAL HISTORY: ***Please check any condition that you currently have or have had in the past***

□Covid-19 Vaccine (please provide copy of card) Date of Most Recent Booster: _____

□High Blood Pressure	□Liver Disease	□Arthritis: OA / RA	□Cancer:_____
□Lung Disease/COPD/Emphysema	□Stroke	□Fibromyalgia/Chronic Pain	□Anemia
□Heart Disease:_____	□Kidney Disease	□Epilepsy/Seizures	□Osteoporosis
□PACEMAKER	□Diabetes	□Bowel/Bladder Dysfunction	□Scoliosis
□Asthma	□COVID-19	□Recent Infection	□Anxiety
□Thyroid Condition:_____	□Lyme Disease	□Headache/Migraine	□Lupus
□High Cholesterol	□Blood Clots	□Chemical Dependency	□Hernia
□Multiple Sclerosis	□Depression	□Hepatitis	□Tuberculosis
□Sexually Transmitted Disease	□Parkinson's	□HIV	□Other:_____

Any NEW ONSET of the following (check all that apply):

□Unexplained Weight Loss/Gain	□Difficulty Swallowing	□ Changes in Bowel/Bladder Function
□Increased Pain at Night	□Headaches	□Depression
□Fever / Chills / Sweats	□Nausea / Vomiting	□Shortness of Breath
□Changes in Appetite	□Loss of vision/ Double vision	□Excessive Fatigue
□Blood in Urine/ Stool	□Dizziness/ Lightheadedness	□Other:_____

During the past month, have you often been bothered by feeling down, depressed or hopeless? Y / N

During the past month, have you often been bothered by little interest or pleasure in doing things? Y / N

Are you allergic to latex? Y / N Do you live alone? Y / N Are you pregnant? Y / N

Do you smoke? Y / N Have you fallen over the past 12 months? Y / N If so, how many times? _____

What activities comprise your typical day: Sitting / Standing / Walking / Lifting / Other:_____

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CURRENT CONDITION:

Describe the reason you are here? _____

_____

_____

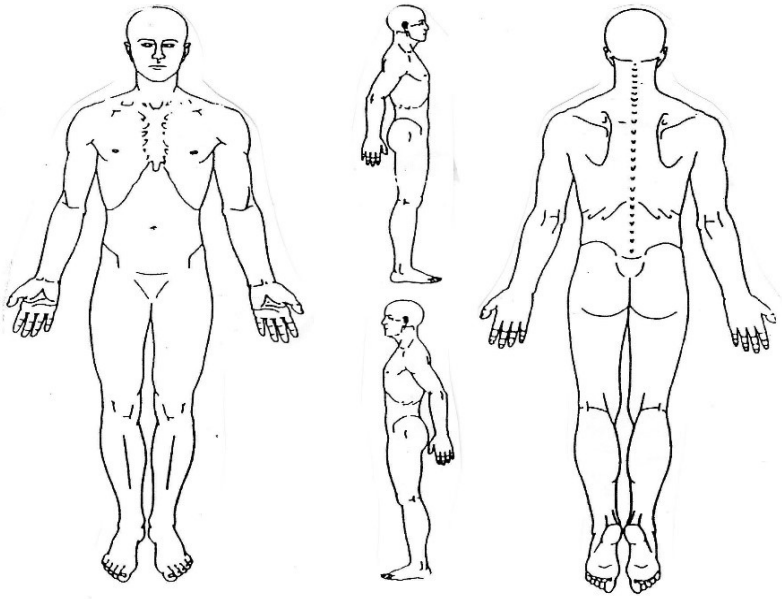
_____

How did symptoms occur? ◻ Gradually ◻ Suddenly ◻ Injury: Home / Work / Auto / Sports / Other

When did symptoms start? _____ Symptoms are: ◻ Getting Better ◻ About Same ◻ Getting Worse

Have you ever had this problem before? Y / N Previous Treatments:_____

Have you had diagnostic imaging for this problem? X-ray / MRI / Ultrasound / CT Scan / EMG / Myelogram



Please mark pain location on the diagrams:

Type of Pain: ◻ Ache ◻ Deep ◻ Burning ◻ Sharp ◻ Shooting ◻ Dull ◻ Stabbing ◻ Throbbing ◻ Numbness ◻ Tingling
Other:_____

Please rate your pain using 0-10 scale:
(0 is no pain at all, 10 is worst pain imaginable)

Current: 0 1 2 3 4 5 6 7 8 9 10

Least: 0 1 2 3 4 5 6 7 8 9 10

Worst: 0 1 2 3 4 5 6 7 8 9 10

What makes your pain worse:_____

What makes your pain better:_____

Please list prior surgeries including dates:

_____

_____

_____

_____

What are your physical therapy and/or fitness goals (write out or complete the sentence that applies to you)?

◻ Decrease pain with: _____

◻ Improve ability to:_____

◻ Leisure activities/Workout Routine:_____

The information above is HIPPA protected and is complete, true, and accurate to the best of my knowledge:

Patient Signature:_____ ***Date:***_____

NEW PATIENT INFORMATION

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Medication Log

Name: ______________________________ Date: ______________

DOB:______________ Height: ______________ Weight: __________

Medicare ***requires*** that we collect data on the specifics of medications you use. Please list all medications, including all prescriptions, over the counter medications, herbals, vitamins, minerals and dietary supplements. Include the dosage, frequency and administration method for each medication.

Medication	Dosage	Frequency	Method of Administration
		As needed Daily: One / Two / Three Other:	Oral / Sublingual Topical / Injection Other:
		As needed Daily: One / Two / Three Other:	Oral / Sublingual Topical / Injection Other:
		As needed Daily: One / Two / Three Other:	Oral / Sublingual Topical / Injection Other:
		As needed Daily: One / Two / Three Other:	Oral / Sublingual Topical / Injection Other:
		As needed Daily: One / Two / Three Other:	Oral / Sublingual Topical / Injection Other:
		As needed Daily: One / Two / Three Other:	Oral / Sublingual Topical / Injection Other:
		As needed Daily: One / Two / Three Other:	Oral / Sublingual Topical / Injection Other:
		As needed Daily: One / Two / Three Other:	Oral / Sublingual Topical / Injection Other:
		As needed Daily: One / Two / Three Other:	Oral / Sublingual Topical / Injection Other:

COMPASS PHYSICAL THERAPY CONSENT TO TREATMENT

Name:_____**DOB:**_____

Notice of Privacy Practices: I acknowledge receipt of Compass Physical Therapy Privacy Policy. ***Initial:*** _____

Authorized Person(s): I authorize you to disclose information about my health, account, and/or treatment to:

_____

Consent to Communicate: Compass PT utilizes digital communications regarding scheduling, treatments provided, home exercise programs, surveys, appointment reminders, and educational information including newsletters, health-related products or services, locations, or providers.

I understand that I am not required to provide the Consent to Communicate above in order to receive medical services from Compass PT, and that I may revoke my Consent to Communicate above at any time by notifying Compass PT. I further understand that text messages are not encrypted and thus are not a secure form of communication.

I hereby authorize Compass PT personnel to communicate via: **Email:** ***Yes / No*** **Text:** ***Yes / No*** ***Initial:*** _____

Notice of COVID Policy: I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with treatment at this time and comply with the posted COVID policy. I confirm that I am not presenting nor had contact with any individuals with COVID symptoms. ***Initial:*** _____

Authorization to Release Information: I authorize the release of any medical or any other information to the Centers for Medicare and Medicaid Services (CMS), my insurance carrier(s), or other entities necessary to determine insurance benefits or benefits payable for related medical services and /or supplies provided to me by Compass Physical Therapy.

Financial Responsibility: I understand that insurance billing, including Workers Compensation Claims, is a service provided as a courtesy and that I am, at all times, financially responsible to Compass PT. It is my responsibility to notify Compass PT of any changes in my health care coverage. I am responsible for the entire bill or balance of the bill as determined by Compass PT and/or my health care insurer if the submitted claims or any part of them are denied for payment. I request that payment of my services is made on my behalf to Compass PT. I understand that Compass PT may, during the course of treatment, recommend purchase of supply items. Supply items may or may not be covered under my insurance plan. I understand that it is my financial responsibility to pay for any item in full if it is not covered under my insurance plan. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for medical services and supply items. I also understand that Compass PT collects for copayments at the time of service by cash, check, credit or debit card***. If using credit or debit card, payments are processed by Bluefin Payment Systems which maintains encrypted credit card data to be used for future payments for services rendered. Checks returned for insufficient fund will be subject to $25 processing fee.***

Cancellation Policy: We require 24hr notice to cancel an appointment. The fee for cancellation without proper notification is $25 per visit. After three (3) missed appointments without proper notification, Compass PT reserves the right to discharge the patient and/or recommend alternative therapy provider.

Consent to Treatment: I consent to and authorize Compass PT to furnish physical therapy care and treatment considered necessary and proper in evaluating and treating my condition.

This is to verify that I have read and agree with the above:

_____ _____

Patient or Responsible Party Date

Notice of Non-Discrimination Policy: Compass Physical Therapy does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. Rev: 3/8/22

COMPASS PHYSICAL THERAPY CONSENT TO TREATMENT

Treatment of Minor: ***(if applicable)***

I authorize Compass Physical Therapy to treat _____ (Minor's name).
I authorize above named minor to attend visits unattended by parent/guardian and sign for his/her self at subsequent appointments: *Yes / No*

This is to verify that I have read and agree with the above:

_____ _____

Responsible Party Date