



General Health Questionnaire:

Today's Date: _____

Patient's Name: _____ Date of Birth: _____ Age: _____

Referring Physician: _____ Hand Dominance: Left Right

Occupation: _____ Able to work with this problem? _____

Tobacco/Nicotine Use: Yes No If yes, type and amount: _____

Exercise: Type of Exercise: _____ How often: _____

Sleep: Hours of sleep per night? _____ Sleep interrupted by your reason for coming to physical therapy? _____

Living Situation: ___ Live alone ___ Live with family/caregivers (Describe: _____)

Type of Home (House, Condo, Apt, etc.): _____ Do you have stairs in your home: _____

CONDITION/DISEASE	Y	N	CONDITION/DISEASE	Y	N	CONDITION/DISEASE	Y	N
Allergies			Endocrine Disease			Lung Disease		
Anemia/blood disorders			Falls			Neurological Disease		
Anxiety			Fibromyalgia			Night pain		
Asthma			Fractures – recent			Osteopenia		
Arthritis			Headaches/Migraines			Osteoporosis		
Autoimmune Disorder			Hearing Impairment			Parkinson's Disease		
Breathing Disorder/difficulty			Heart disease			Pregnancy		
Cancer of any type			Hepatitis: A, B or C			Rheumatoid Arthritis		
Cardiac Pacemaker			High cholesterol			Seizures/Fainting		
Chemical Dependency			High blood pressure			Stroke		
Circulation Problems			HIV/AIDS			Thyroid Disease		
Concussion/Head Injury			Hypoglycemia			TMJ (jaw) disorders		
Depression/mental health			Incontinence			Ulcers/Stomach issues		
Diabetes			Kidney Disease			Urinary Tract Infection		
Dizziness			Liver Disease			Other:		

Please explain any necessary details for the health concerns noted above: _____

List any surgeries and dates: _____

List any medications and dosages (or you can provide us with a list we can copy): _____

For Office Use: (To be taken by staff)

Height	Weight	Blood Pressure	Pulse	Oxygen Sat.	Taken by

History of your current condition:

What are we treating you for? _____

When did you first notice the symptoms (give a specific date if possible)? _____

Was the onset of your symptoms gradual or sudden? _____

Which of the following best describes your symptoms? (Please check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Disorientation | <input type="checkbox"/> Pain in ears |
| <input type="checkbox"/> Imbalance | <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Vertigo | <input type="checkbox"/> Nausea | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Blurry/jumping vision | <input type="checkbox"/> Other: _____ | |

Since the onset, are your symptoms getting: Better Worse Staying the same

Are your symptoms: Constant Provoked by head movement or activity Spontaneous (without a cause)

What aggravates your symptoms? (Please check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Sitting up or laying down | <input type="checkbox"/> Going from sitting to standing |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Riding in or driving a car |
| <input type="checkbox"/> Busy environments | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Other: _____ | |

Do you experience any neck pain or headaches? _____ If so, how often: _____

Rate your current neck pain: 0---1---2---3---4---5---6---7---8---9---10

No pain Worst pain

Rate your current headache: 0---1---2---3---4---5---6---7---8---9---10

No pain Worst pain

Have you had any recent medication changes? _____

Have you had any previous treatment for this condition? _____ If so, please describe: _____

Have you seen a chiropractor recently? _____

Have you had any medical tests for this condition? (X-rays, MRI, CT scan, etc.)? _____

Have you had any falls in the past year? If yes, describe the fall and frequency and if there was an injury: _____

List activities you do not do because of your symptoms _____

Is there any other pertinent information to your current condition that we should know? _____

Patient Registration:

Last Name: _____ First Name _____ M.I. _____ Gender: _____

Date of Birth: _____ Age: _____ Marital Status: _____ SS#(or DL#): _____

Mailing Address: _____ City: _____ State: _____

Home Phone: _____ Cell Phone: _____ Zip Code: _____

Email Address: _____ Spouse's Name (if applicable): _____

Occupation: _____ Employer: _____

Employer Address: _____ Employer Phone: _____

Primary Care Physician: _____ Referring Physician: _____

Is the reason we are treating you related to a work injury or motor vehicle accident? YES NO

Emergency Contact Information:

Name: _____ Relationship: _____

Phone: _____

Appointment Reminders: *Please indicate which methods of communication you prefer.*

Yes	No	Email (to address provided above)
Yes	No	Phone call/voice mail message (to phone numbers provided above)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize the release of any information acquired in the course of my treatment to my insurance carrier and physician, any authorized representative as appointed from time to time, and those people listed below, which authorization may be revoked in writing at any time:

Individual(s) Name:	Relationship to Patient:
_____	_____
_____	_____

Payment Expectations:

If you have an insurance plan that requires a **co-pay** for each visit, we are contractually obligated by your insurance company to collect it **at the time of your visit.**

If you have a **high deductible** health insurance plan with a deductible of \$1000 or more and have not met your deductible, we require an account payment towards the balance on your account at the check in of each visit as follows:

Evaluation: \$200 Regular Treatment: \$125

Self Pay Patients: (without any insurance) must pay the **full amount due** at the end of each appointment.

Medicare Beneficiaries: Have you had a recent Home Health or Hospice visit? **Yes No**

Signature of Patient (or Parent/Legal Guardian)

Date

Patient Name: _____

Parent or Legal Guardian Information (if patient is under the age of 18):

Name: _____ Relationship: _____

Date of Birth: _____ Gender: _____ SS# (or DL#): _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

Employer: _____ Employer Phone: _____

Financial Guarantor (if different than above):

Name: _____ Relationship: _____

Date of Birth: _____ Gender: _____ SS# (or DL#): _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

Additional Parent or Guardian authorized to receive medical information and schedule appointments:

Name: _____ Relationship: _____

Signature of Patient (or Parent/Legal Guardian)

Date

PATIENT CONSENTS AND AUTHORIZATIONS

CONSENT TO RECEIVE PHYSICAL AND OCCUPATIONAL THERAPY SERVICES: I consent to the evaluation and treatment performed by my licensed physical or occupational therapist. The treatment procedures *may* include manual therapy, high velocity/low amplitude mobilization, dry needling, laser therapy, ultrasound, phonophoresis, electrical stimulation, iontophoresis, heat/cold therapy, mechanical traction, neuromuscular re-education, therapeutic exercise and therapeutic activities. My treatment plan will be based on my current presentation and the best clinical judgement of my physical or occupational therapist. Serious complications or injuries resulting from physical therapy procedures are very rare and all risks will be carefully managed by my physical therapist. Possible risks include, but are not limited to, an increase in pain, bruising, burns, bone fracture, cardiovascular complications, puncture of the lung (pneumothorax), infection and nerve injury. I understand that there are inherent risks associated with participation in physical therapy and will address any specific concerns or questions with my Physical Therapist during my appointment. I understand that I have the right to terminate any part of my physical therapy treatment at any time. I understand that no guarantees have been made regarding the outcome of the treatments provided.

AUTHORIZATION OF INSURANCE PAYMENT AND FINANCIAL RESPONSIBILITY: I authorize payment directly to Advanced Rehabilitation Services, LLC for services rendered. I understand it is my responsibility to know my insurance benefits and how physical therapy services are covered under my plan. I accept full responsibility for payment of services not covered by my insurance. I understand that if my account is not paid in full, I am subject to be charged for any additional fees incurred by Advanced Rehabilitation Services, LLC to collect my balance, including 15% APR or 1.25% monthly on all balances not paid within 30 days of invoice date or maximum extent allowed by state and federal law. ARS reserves the right to refuse treatment to any person with outstanding balances that have not made attempts to pay balance due.

AUTHORIZATION FOR TREATMENT OF A MINOR (IF APPLICABLE): I authorize Advanced Rehabilitation Services, LLC to provide the appropriate care and treatment for the minor named above. This authorization allows the therapists to treat the minor if/when I am not present for the treatment for the duration of this plan of care. The parent or legal guardian accepts full responsibility for payment in full for this account.

COMMUNICATION & APPOINTMENT REMINDER CONSENT: By providing my phone number(s) and/or email address, I consent to receive communication from the clinic using these methods to communicate with me regarding my care. If I choose to communicate with ARS staff using email or text message concerning my care, I understand that Advanced Rehabilitation Services, LLC has reasonable safeguards in place for my protected health information (PHI). By signing below, I consent to sending and receiving information regarding my care electronically, and accept the inherent risks of submitting information electronically. Pursuant to HIPAA guidelines, ARS is required to notify me in the event my PHI is compromised.

CANCELLATION POLICY: ARS requires 24 hours notice in the event of a cancellation. ARS reserves the right to charge a \$35 fee for a “no-show” to an appointment without any notice or cancellation without 24 hours notice (“Cancellation Fee”). This charge will not be billed to my insurance company. By signing below, I expressly agree to be charged and pay the Cancellation Fee prior to the start of my next treatment visit.

NOTICE OF PRIVACY PRACTICES FOR MY PROTECTED HEALTH INFORMATION: I have been offered and/or given a copy of the HIPAA notice and have had a chance to ask questions about how my personal health information will be used. I know that I can contact the privacy official, Jennifer Reynolds, at (406) 752-7250 if I have further questions.

I have reviewed the consents and policies above and I agree to all of the statements.

Signature of Patient or Parent/Legal Guardian

Date