PATIENT INFORMATION

Name: _____ DOB: _____ Age: ___

Address: _____Sex:_____

City: _____ State: _____ Zip: _____

Email address: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Responsible Party (if different from above)

Name: _____ DOB: _____

Address: _____ E-mail: _____

City: _____ State: _____ Zip: _____

Email address: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Referring Physician

Name: _____Phone:_____ Date of Last Visit: _____

City/State: _____ Date of Surgery: _____

Employer Information

Name: _____ Address: _____

Phone: _____ Occupation: _____

Hours worked per week: _____ Activities during work (sitting, walking, etc.): _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

How did you hear about us?_____

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Charlottesville, VA 22901
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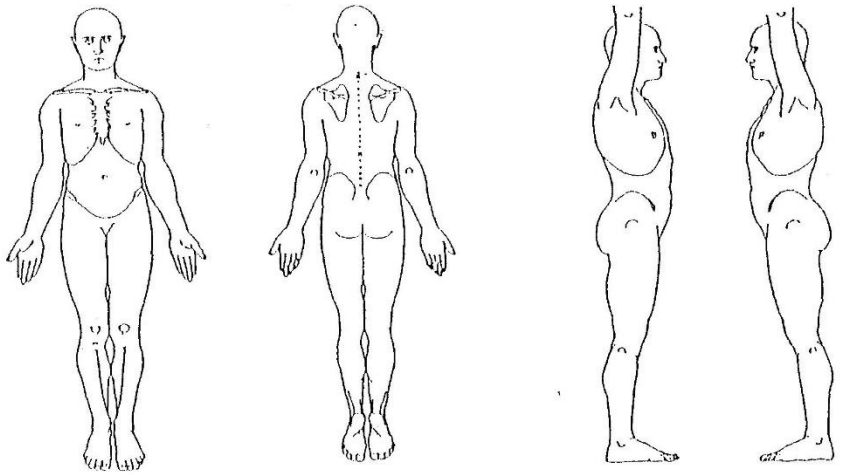
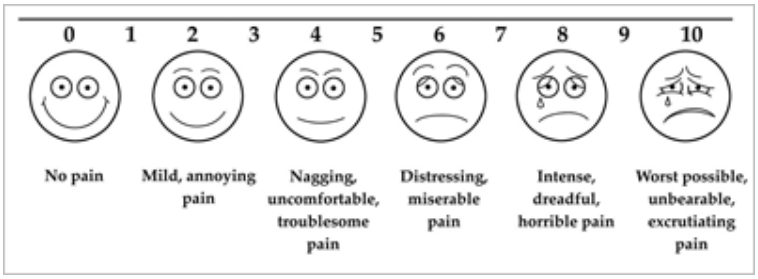
Current Medical History:
Pain related to current injury



Use X marks to show where you feel pain, numbness, tingling. Circle the level of pain on the scale below and describe your pain (i.e. sharp, dull, achy, burning, deep, radiating, etc.)



Chief complaint (why patient is seeking physical therapy care): _____

Date of injury: _____

What do you think caused your pain? Why? _____

Since its initiation, has the pain changed? (worse, better or same) _____

Is there anything that increases your pain? _____

What eases your symptoms? _____

Are you taking any medications, vitamins and supplements? ( ) Yes ( ) No If yes, list below with dosage

_____

What are your goals for physical therapy? _____

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PAST MEDICAL HISTORY

Have you ever had any of the following? If yes, please briefly note date and specifics:

1. Surgeries? ( )Yes ( ) No _____

2. Have you fallen in the past year and if so how many time? _____ Why did you fall? _____

3. Are you pregnant? (weeks) ( ) Yes ( ) No _____

4. Females do you have an IUD? ( ) Yes ( ) No

5. Other problems that have been diagnosed by a physician? ( )Yes ( )No

   _____

6. Are you currently under the care of a doctor of medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner, or licensed physicians assistant for the symptoms you are seeking physical therapy?
   ( ) Yes ( ) No If yes, name of practitioner you are seeing: _____

REVIEW OF SYSTEMS

Please mark the appropriate 'NO' lines, or provide details

NO		DETAILS
___	General (i.e. fever or chills, poor general health, unexplained weight loss, fatigue, unexplained sweating)	_____
___	Skin (i.e. rashes, new skin lesions, or a change in moles)	_____
___	Eyes (i.e. blurred vision, or change in visual acuity)	_____
___	Ears (i.e. ear pain, or difficulty hearing)	_____
___	Nose (i.e. nasal congestion, discharge, or bleeding)	_____
___	Mouth/Throat (i.e. sore throat or difficulty swallowing)	_____
___	Respiratory (i.e. shortness of breath, cough, wheezing)	_____
___	Cardiovascular (i.e. high/low blood pressure, palpitations)	_____
___	Gastrointestinal (i.e. nausea, vomiting, diarrhea, constipation, abdominal pain, discolored stools)_____	
___	Genitourinary (i.e. problems initiating or controlling my bladder, or have problems with urinary frequency)	_____
___	Endocrine (i.e. diabetes, excessive thirst, glandular issues)	_____
___	Blood disorders (i.e. bruise easily, bleeding)	_____

NO

___ Psychiatric (i.e. depression, anxiety, suicidal thoughts or attempts) _____

___ Cancer _____

___ Past Orthopedic Injuries (i.e. sprains fractures etc.) _____

All information listed above is accurate as of today's date and I agree to notify High Gear Physical Therapy, LLC of any changes in my medical status while under their care.

_____	_____	_____
Patient/Guardian Printed Name	Signature	Date

Patient Policies and Consent for Assessment and Treatment Procedures

- High Gear Physical Therapy, LLC is an out of network provider of physical therapy.
- High Gear Physical Therapy, LLC is not a Medicare provider and cannot submit claims to Medicare for our patients. Medicare will not cover physical therapy services performed at High Gear Physical Therapy, LLC. Services provided to Medicare recipients will be performed as a wellness, maintenance, preventative and fitness model.
- High Gear Physical Therapy, LLC can submit necessary paperwork to your insurance carrier, except for Medicare, if requested, however the patient is responsible for all fees at the time of service.
- I authorize High Gear Physical Therapy, LLC to submit all necessary information and claims necessary for payment from the patient's insurance carrier.
- A $100 fee will be charged to the patient for all visits for which the patient no-shows or cancels without 24 hours' notice.
- No guarantees have been made to me about the outcome of my physical therapy care.
- I understand that there are inherent risks involved when performing physical therapy and exercise although these risks have been shown to be minimal.
- I authorize High Gear Physical Therapy, LLC to release information regarding my medical history, treatment, examination results, progress and diagnosis to my physician, other health care providers involved in my care and any insurance carriers.
- I hereby authorize High Gear Physical Therapy, LLC to e-mail me and text me to provide copies of receipts, chart notes and schedule reminders via the e-mail and cell phone provided.
- I acknowledge that I have received and/or read a copy of the Privacy Practices for High Gear Physical Therapy, LLC available at highgearpt.com and I consent to the use of my personal health information for the purpose of treatment, payment and health care operations.
- If my account is sent to an outside collections agency, I will be responsible for all fees associated with collecting my account plus a $200 administrative fee payable to High Gear Physical Therapy, LLC.
- I hereby authorize High Gear Physical Therapy, LLC through its appropriate personnel, to perform, or have performed upon me, or the above named patient, such assessment and treatment procedures as are deemed necessary.
- I hereby acknowledge that if this injury is in any way related to a motor vehicle accident or an accident that happened at a workplace that I have informed the staff of this situation.

Patient's printed name: _____

Patient's Signature: _____ Date: _____

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