Version 2.0 – 12/21

# Patient Information

Patient Name: _____
Last Name First Name Middle Initial

Male ☐ Female ☐ Non-Binary ☐

Address: _____
Street City State Zip Code

Cell#: _____ Home#: _____ Work#: _____

DOB: _____ SS#: _____ Marital Status: S ☐ M ☐ W ☐ D☐

Email Address: _____

If Patient is minor, please indicate Parent guarantor name _____ and DOB: _____

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**Emergency Contact**

Name: _____ Relationship: _____

Phone#: _____

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**Physician's Info**

Referring Physician: _____ Phone#: _____

Diagnosis or body part: _____

Sport/activity?_____

Concussion? YES ☐ / NO ☐ From sports? YES ☐ / NO ☐

Have you seen a Chiropractor, Acupuncture or had Physical Therapy for this injury somewhere else? YES ☐ / NO ☐ Number of visits:_____

# Integrative Touch Physical Therapy
# Sabine Combrie, MPT, CST-T
# Physical Therapist, Cranio Sacral Therapist

## Release Of Liability

I certify that I have NO current or prior medical condition that would interfere with me receiving a treatment procedure from our licensed professional nor has a qualified medical person advised me otherwise. I understand that a Physical Therapist or a Cranio Sacral Therapist neither diagnoses illness, disease or any medical, physical or mental disorder.

I understand that there are certain risks associated with receiving a treatment procedure from Integrative Touch Physical Therapy, including but not limited to discomfort, pain, muscle spasm, and possible aggravation of an existing condition. I knowingly and freely assume all such risks, both known and unknown, and assume FULL responsibility for my participation. If at anytime I experience discomfort, muscle spasm, or any other adverse reaction, I will immediately notify the practitioner and request that the treatment procedure be modified or terminated. I further understand that it is the right of the therapist to refuse or discontinue treatment at any time.

I, for myself and on the behalf of my heirs, assigns, personal representatives and next of kin, hereby release and hold harmless Integrative Touch Physical Therapy and Sabine Combrie, Physical Therapist, Cranio Sacral Therapist, their/her agents and/or employees, and if applicable, owners and lessors of premises used to conduct the Physical Therapy or Cranio Sacral Therapy session/procedure with respect to any and all injury disability, loss or damage to person or property to the maximum extent permissible under applicable law. I have read this release of liability and assumption of risk agreement, fully understand its terms and understand that I have given up substantial rights by signing “Freely and Voluntarily” without “ ANY inducement”

Print name:_____ Date:_____

Patient signature:_____

# Patient Authorization (Please read carefully)

## No Show/Cancellation policy

Specific time is reserved for you when you scheduled an appointment. If you cannot keep your scheduled appointment time, you must cancel at least 24 hours in advance. There will be a charge for NO SHOW appointments or cancellations with less than 24hours notification. You agree that you will be personally responsible for any cancellation fees.

## Check return policy

In the event that the bank returns your check as non sufficient fund, our office will automatically charge $25:00 to your account per attempt/per check, in addition to the amount due for service rendered.

## Consent

I authorize Integrative Touch Physical Therapy to provide my treatment as prescribed by my physician, or by self-referral.

## Payment of benefits to Integrative Touch Physical Therapy

**I understand that I am financially responsible for services rendered by Integrative Touch Physical Therapy.**

**Integrative Touch Physical Therapy is only contracted with MEDICARE; any other insurance plans will consider Integrative Touch Physical Therapy as Out of Network provider.**

Integrative Touch Physical Therapy will bill MEDICARE and 2$^{ndary}$ to MEDICARE insurance policies. For patients with any other insurance plans, as a courtesy to its valued patients, Integrative Touch Physical Therapy will print a superbill that patients can submit to their insurance companies for reimbursement directly to the patient.

## HIPPAA privacy practices policy

Our Notice of Privacy Practices provides information about how we may disclose protected health information about you. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. Be aware that your restriction might affect how insurances process your claim. By signing this form, you consent to our use and disclose of protected health information about you for your treatment and payment. You have the right to revoke this consent, in writing, except where we have already made disclosure in reliance on your prior consent.

I have read and fully understand the above-referenced policies and do hereby to comply.

Print name:_____ Date:_____

Patient signature:_____

# Physical Therapy Patient History

Name: _____ DOB: _____

Today's Date: _____

Age: _____ Height: _____ Weight: _____ Male ☐ or Female ☐

Handedness: Right ☐ / Left ☐

Occupation: _____

Are you currently off work because of this problem? Yes ☐ No ☐ Light duty ☐

Diagnosis: _____ Referral source: _____

When did your problems begin? _____

How did your problems begin? _____

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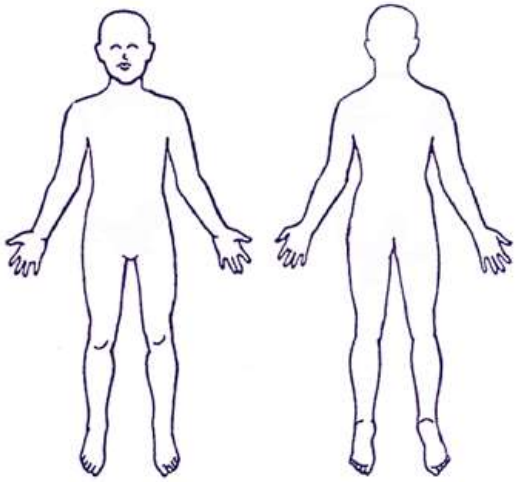
1. Rate your pain: No Pain 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Worst Pain
2. Draw your pain:



3. Describe your pain: ☐ Dull ☐ Ache ☐ Sharp ☐ Stabbing ☐ Pins & Needles ☐ Shooting ☐ Pain ☐ Burning ☐ Throbbing ☐ Twinge ☐ Numbness/Tingling ☐ Other:_____

4. Is your pain constant? Yes ☐ No ☐
5. Intermittent? Yes ☐ No ☐
6. Fluctuates with activity? Yes ☐ No ☐
7. Wakes you up at night? Yes ☐ No ☐

8. What makes your symptoms worse?

☐ Sitting ☐ Standing ☐ Walking ☐ Lifting ☐ Bending ☐ Lying down ☐ Squatting ☐ Stress ☐ Other:_____

9. Are you ever totally pain free? Yes ☐ No ☐

10. What makes your symptoms better?

☐ Sitting ☐ Standing ☐ Walking ☐ Lifting ☐ Bending ☐ Lying down, ☐ Other:_____

11. What time of day are your symptoms worst? _____ Best? _____

12. Do you feel you are: ☐ Getting better, ☐ Getting worse, ☐ Staying the same?

13. Have you had this problem before? Yes ☐ No ☐

14. If yes, when and how did it get better? _____

15. Any previous treatment for your current condition? Yes ☐ No ☐

16. Have you had diagnostic studies for your current condition? (X-ray, MRI, CT scan) Yes ☐ No ☐

17. Any other orthopedic problems? Yes ☐ No ☐

If yes, please explain: _____

18. Any medical problems? Yes ☐ No ☐

If yes, please explain: _____

19. Any surgeries? Yes ☐ No ☐

If yes, please explain: _____

20. Please list **ALL** medications you are currently taking such as prescription and over- the-counter for this and any other condition

_____

_____

_____

21. Have you ever had a history of any of the following?

| | | | |
|---|---|---|---|
| ☐ Major injury to head/spine | ☐ Cancer/tumors | ☐ Osteoporosis | ☐ Dizziness/blackouts |
| ☐ Heart problems/angina | ☐ Diabetes | ☐ Pacemaker | ☐ High blood pressure |
| ☐ Severe pain at night | ☐ Smoking | ☐ Bruising easily | ☐ Asthma |
| ☐ Loss of bowel/bladder control | ☐ Frequent falls | ☐ Numbness | ☐ Seizures/epilepsy |
| ☐ Sudden weight loss/gain | ☐ Coordination loss | ☐ Osteopenia | ☐ Stroke |

22. Does your current condition limit you in carrying out job duties? ☐ Yes ☐ No ☐
Household duties? ☐ Yes ☐ No ☐

23. What are your goals in physical therapy?

_____

_____

_____

## HEALTH QUESTIONNAIRE

PLEASE CHECK YES OR NO FOR THE ANSWER THAT APPLIES TO YOU

| | | |
|---|---|---|
| 1. Fever/chills/sweats | ☐ YES | ☐ NO |
| 2. Malaise (feeling generally unwell) | ☐ YES | ☐ NO |
| 3. Unusual fatigue | ☐ YES | ☐ NO |
| 4. Nausea/vomiting | ☐ YES | ☐ NO |
| 5. Weakness | ☐ YES | ☐ NO |
| 6. Chest pain/palpitations | ☐ YES | ☐ NO |
| 7. Swelling in feet/hands | ☐ YES | ☐ NO |
| 8. Difficulty breathing/shortness of breath | ☐ YES | ☐ NO |
| 9. Difficulty breathing when lying down | ☐ YES | ☐ NO |
| 10. Cough/change in cough/blood in phlegm | ☐ YES | ☐ NO |
| 11. Wheezing | ☐ YES | ☐ NO |
| 12. Difficulty swallowing | ☐ YES | ☐ NO |
| 13. Heartburn indigestion | ☐ YES | ☐ NO |
| 14. Change in appetite | ☐ YES | ☐ NO |
| 15. Specific food intolerance | ☐ YES | ☐ NO |
| 16. Difficulty urinating (starting/stopping) | ☐ YES | ☐ NO |
| 17. Urine frequency changes | ☐ YES | ☐ NO |
| 18. Pregnancy | ☐ YES | ☐ NO |

- Are you allergic to any medication?_____

- Are you allergic to Latex Yes ☐ No ☐
  Tape adhesive Yes ☐ No ☐

Thanks for taking the time to fill out this form as completely as possible! It will save us on treatment time during your first visit and will help in assessing your condition and guiding your treatment plan.

I hereby _____, certifies that all of previous pages and above personal information are true and accurate.

Signature:_____ Date:_____