FIT PARSONS PT

fitparsons.com | 424.290.0096

Date _____

Patient First _____ **Last Name**_____

Address _____

City: _____ **State:** _____ **Zip**_____

Parent/Guardian Name & Relationship(s)_____

Parent/Guardian Marital Status: Married Divorced Single Widowed Domestic Partnership

Physical Custody: _____**Legal** _____

Cell Phone: _____ **Work Phone**: _____

Email: _____

May We: **Text You?** Yes / No **Leave a Message?** Yes / No **Email You:** Yes / No

Patient Date of Birth: _____ **Age:** _____ **Sex** M / F

Consent to TeleHealth? Yes / No **Occupation**: _____

Employment Status: Full Time Part-Time Not Working Retired Self-Employed Student

Employer: _____

Employer Address: _____

Referring Doctor: _____ **Phone**_____

Primary Doctor: _____ **Phone**_____

Emergency Contact _____ **Relationship** _____

Emergency Contact Phone Number: _____

How did you hear of FIT PARSONS? _____

What brings you to PT? _____

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Date of Injury / Onset Date: _____ **Surgery Date:** _____

Surgery Type (if applicable): _____

Is this Auto Related? Yes / No **Work Related?** Yes / No **Accident Related?** Yes / No

Is there an attorney involved? Yes / No

How much pain do you have from 0 (no pain) to 10 (worst pain imaginable)? _____

Would you say your condition is: Improving Staying the same Getting Worse

What helps your condition feel better?_____

What makes your condition feel worse:_____

Please List ANY Allergies you have: _____

Please list all diagnostic exams you have had for your current condition (xrays, MRI, etc)

_____

Please list any surgeries (and dates) you have had: (separate sheet if needed)

_____

_____

Please list all medications (and doses) you are currently taking: separate sheet if needed

_____

_____

Other serious health info FIT PARSONS should know about me:

_____

_____

Goals for Physical Therapy _____

Do you or have you had any of the following: Circle all that apply and Explain

CONDITION	DATE	EXPLAIN
Chest Pain or Shortness of Breath		
High Blood Pressure		
Type I or Type II Diabetes		
High Cholesterol		
Cancer and Type		
Pain that is Worse at Night		
Active Infection, Fevers, Chills, Cold Sweat		
COPD / Heart Attack / Heart Disease / Pacemaker		
Stroke or CVA		
Metal Implants or Pins and where?		
Seizures / Epilepsy / Unexplained falling		
Headaches / Migraines / Blurred Vision		
Dizziness / Ringing in Ears / Difficulty Swallowing		
Blood Clots / DVT / Pulmonary Embolism		
Do you smoke? Packs x Years		
Osteoporosis / Osteopenia		
Unexplained weight gain or loss		
HIV / AIDS or other Auto-Immune Diseases		
Hepatitis / TB		
Are you pregnant?		
Loss of Bowel / Bladder control		
Any Neurological Disorders		
Other Diagnosis / Conditions not Listed Above		

FIT PARSONS NOTICE OF PRIVACY PRACTICES AND TERMS OF SERVICE AGREEMENT

By signing below, I acknowledge that I have been provided with a copy of the Notice of Privacy Practices and Terms of Service Agreement in a downloadable pdf format located on the www.fitparsons.com website and have therefore been advised of how health information about me may be used and disclosed by FIT PARSONS. I understand I may obtain access and control this information. By signing below, I am in agreement with these privacy practices and terms of service and I consent to the services provided to me by FIT PARSONS PT.

For a Summary of your Privacy Rights covered under HIPPA, please download:

https://www.hhs.gov/sites/default/files/privacysummary.pdf

FINANCIAL RESPONSIBILITY

FIT PARSONS does not accept insurance and payment is due when services are rendered and it is my financial obligation to pay at the time of service. We accept Venmo, PayPal, Cash, and check.

By signing below, I am acknowledging I understand and consent to the TERMS OF SERVICE as a patient of FIT PARSONS. I understand my rights and agree to and accept full responsibility for my financial obligations to FIT PARSONS. I also acknowledge the information that I have provided is true and accurate to the best of my knowledge.

_____ _____

Patient's Printed Name Date

_____ _____

Signature Relation to Patient

MEDICATIONS	DOSE	FREQUENCY (TIMES/DAY)

TYPE OF SURGERY	DATE	LEFT / RIGHT SIDE