FIT
PARSONS PT
Dr. Stacey Parsons, DPT, OCS, CSCS

Office: 424.290.0096 | Fax: 424-408-3320
www.fitparsons.com

Date ________________

Patient First __________________________ **Last Name**________________________

Address ____

City: ________________________________ **State:** ______ **Zip**_________________

Parent/Guardian Name(s) & Relationship(s)___________________________________

Parent/Guardian Marital Status: Married | Divorced | Single | Widowed | Domestic Union

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: ____

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 an attorney involved? Yes | No **Current/Former smoker?** Yes | No **Pregnant?** 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: ____

Diagnostic exams you have had for your current condition (x rays, MRI, CT scan, etc)

____

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

____

____

Medications (and doses) you are currently taking: (separate sheet if needed)

____

____

Goals for Physical Therapy ____

____

____

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

High Blood Pressure	Neurological Disorders
High Cholesterol	Unexplained Falling
Type I or Type II Diabetes	Pain Worse at Night
Heart Attack or Heart Conditions	Unexplained Weight Loss / Gain
Pacemaker	Headaches or Blurred Vision
Cancers of any kind	Dizziness or Ringing in Ears
COPD, Asthma, Emphysema	Difficulty Swallowing
Stroke or Blood Clots	Active Infection, Fevers, Chills
Seizures/Epilepsy	Loss of Bowel / Bladder Control
HIV / AIDS	Osteoporosis / Osteopenia
Hepatitis B	Metal Implants & Location

Explain the above & any other health info FIT PARSONS should know:

____

____

____

____

____

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Pediatric Patients Only:

Weeks gestation at birth ______________ Vaginal | C-Section Complications: Yes | No

Breastfeeding / Pumping for how long? _________________ Nap schedule: ____________

Siblings & Age(s) ____________________________________ Eats solids: Yes | No

Any relevant details & age when your child started:

- Rolling ____
- Sitting ____
- Crawling ____
- Pull to stand ____
- Cruising ____
- Standing independently ____
- Squatting ____
- Walking ____

Aside from parents, who is another primary caregiver? nanny | daycare | grandparent | other

School attending: ______________________________________ Grade: ___________

Additional health info & details about your child I should know:

____

____

____

____

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Consent to Treatment

TO THE PATIENT: You have a right to be informed about your condition and the recommended medical procedure to be performed so you can make an educated decision whether or not to proceed with care after knowing the risks and benefits involved.

This consent form gives your permission to perform the evaluation necessary to identify the appropriate treatment/ procedure for any and all identified condition(s). This consent provides your permission to perform reasonable and necessary medical examinations and treatment.

By signing below, you are indicating that:
(1) this consent is continuous in nature even after a specific diagnosis has been made and treatment recommended.
(2) you consent to treatment at this office or any satellite office under common ownership. The consent will remain fully effective until you revoke it in writing.
(3) you consent to telehealth services (if appropriate) that occur via live audio and/or video on a HIPPA compliant platform (potential privacy risks may still exist, so please turn on privacy/encryption mode when using).

I understand that if I have any concerns regarding the purpose, risks and benefits of any test and procedures recommended or provided, I can discuss it with my PT or MD. I also understand that I can decline and discontinue any service at any time.

I voluntarily consent to treatment with FIT PARSONS PT as deemed necessary, to perform reasonable and necessary medical examination and treatment for the condition which has brought me to seek care at this practice. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

______________________________ ______________________
Signature of Patient or Personal Representative — Date

______________________________ ______________________
Printed Name of Patient — Date

______________________________ ______________________
Printed Name of Personal Representative — Relationship to Patient

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NOTICE OF PRIVACY PRACTICES AND TERMS OF SERVICE AGREEMENT

I acknowledge that I have obtained a copy of FIT PARSONS Privacy Practices and Terms of Service Agreement located at www.fitparsons.com. I understand how health information about me may be used and disclosed by FIT PARSONS. By signing below, I am in agreement with the privacy practices and the terms of service. I consent to the services provided to me by FIT PARSONS.

For a Summary of your Privacy Rights under HIPPA:
https://www.hhs.gov/sites/default/files/privacysummary.pdf

FINANCIAL RESPONSIBILITY

FIT PARSONS does not accept any insurance and payment is due on the date services are rendered. I agree with my financial obligation to pay at the time of service. Forms of payment accepted are Venmo, Zelle, cash & check.

CANCELLATION POLICY

Any cancellation within 8 hours of your scheduled appointment date/time will be charged the full cost of one visit.

The information I have provided is true and accurate to the best of my knowledge.

By signing below, I accept full responsibility, I understand & agree with the policies set forth below by FIT PARSONS and would like to proceed with care.

- **Consent to Treatment**
- **Agree with the Terms of Service**
- **Agree with the Cancellation Policy**
- **Agree with the Financial Policy**

Signature of Patient or Personal Representative	Date
Printed Name of Patient	Date
Printed Name of Personal Representative	Relationship to Patient