

Name: _____ Phone #: _____

Preferred name if different from insurance/ID: _____

Pronouns (circle): She/Her He/His They/Them Other: _____

Address: _____

SS number: _____ DOB: _____ Height: _____ Weight: _____

Emergency contact/relationship: _____ Phone #: _____

Circle appropriately

Are you latex sensitive? **YES NO** Do you smoke? **YES NO**

Do you have a pacemaker? **YES NO** Do you have hearing loss? **YES NO**

Are you currently pregnant or think you might be pregnant? **YES NO**

ALLERGIES: List any allergies: _____

Have you RECENTLY noted any of the following (check all that apply)?

- | | | |
|---|---|--|
| <input type="checkbox"/> fatigue | <input type="checkbox"/> numbness or tingling | <input type="checkbox"/> constipation |
| <input type="checkbox"/> fever/chills/sweats | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> dizziness/lightheadedness | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> weight loss/gain | <input type="checkbox"/> heartburn/indigestion | <input type="checkbox"/> fainting |
| <input type="checkbox"/> difficulty maintaining balance while walking | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> cough |
| <input type="checkbox"/> falls | <input type="checkbox"/> changes in bowel or bladder function | <input type="checkbox"/> headaches |

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|---|---|--|
| <input type="checkbox"/> cancer | <input type="checkbox"/> depression | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> lung problems | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> chest pain/angina | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> asthma | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> circulation problems | <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> other arthritic condition | <input type="checkbox"/> eye problem/infection |
| <input type="checkbox"/> stroke/ head injury | <input type="checkbox"/> bladder/urinary tract infection | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> anemia | <input type="checkbox"/> kidney problem/infection | <input type="checkbox"/> liver problems |
| <input type="checkbox"/> bone or joint infection | <input type="checkbox"/> sexually transmitted disease/HIV | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> chemical dependency (i.e., alcoholism) | <input type="checkbox"/> pelvic inflammatory disease | <input type="checkbox"/> pneumonia |

Circle appropriately

During the past month have you been feeling down, depressed or hopeless? **YES NO**

During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**

Is this something with which you would like help? **YES YES, BUT NOT TODAY NO**

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|--|-------------------------------------|---|
| <input type="checkbox"/> cancer | <input type="checkbox"/> diabetes | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> stroke | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> depression | <input type="checkbox"/> blood clots |

Please list all medications you are currently taking: (including dosages and frequency):

-Blood Pressure Medication -Heart Medication -Anti-coagulants (blood thinners)

-Muscle Relaxants -Pain Killers -Diabetes Medication (i.e. insulin)

-Steroids -Anti-inflammatories -Other Medications (state condition)

Have you ever taken steroid medications for any medical conditions? **YES NO**

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**

Please List all surgeries you have had (include dates): _____

What date (roughly) did your present symptoms start? _____

What do you think caused your symptoms? _____

My symptoms are currently: Getting Better Getting Worse Staying about the same

Treatment received so far for this problem (chiropractic, injections, etc) _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

Have you ever had this problem before: Yes No When _____ Treatment rec'd _____

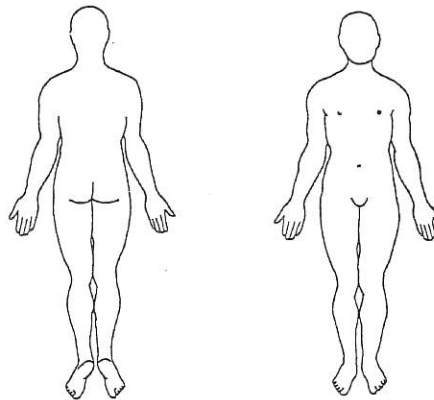
Occupation, including activities that comprise your workday: _____

Leisure activities, including exercise routines: _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

- ↓ Shooting/sharp pain
- Dull/aching pain
- ||| Numbness
- = Tingling



My symptoms currently: Come and go Are Constant Are constant, but change with activity

Aggravating Factors: Identify important positions or activities that make your symptoms worse:

Easing Factors: Identify important positions or activities that make your symptoms better:

How are you currently able to sleep at night due to your symptoms?

No problem sleeping Difficulty falling asleep Awakened by pain Sleep only with medication

When are your symptoms worst? Morning Afternoon Evening Night After exercise

When are your symptoms the best? Morning Afternoon Evening Night After exercise

Using the 0 to 10 the scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:

Your current level of pain while completing this survey: _____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature – Relationship to Patient

(Date)

Consent to Treat

1. I have presented myself to this facility for therapy treatments and consent to the care (history, physical examination, treatment, etc.) that will be provided by my therapist.
2. I realize I have the right to refuse any treatments or procedures to the extent permitted by law. I acknowledge that the delivery of health care does not guarantee results of any treatments at this facility.
3. I understand that information from any medical record(s) kept by this facility may be used for educational, administrative, and/or facility approved purposes when my personal identity will not be revealed.
4. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service. I am responsible for any services not covered by this authorization. I have read and fully understand the Patient Financial Responsibilities Form.
5. Worker's Compensation - I hereby authorize Pappas OPT to receive my records related to my work injury.

Photo/Video Authorization

I grant to Pappas OPT and its affiliated entities, and its representatives and employees (collectively the "Company") the right to take photographs and/or videos of me in connection with my participation in physical/occupational therapy services. I authorize the Company, to copyright, use and publish the same in print and/or electronically. I agree that the Company may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content and waive any right to compensation, therefore. I understand that I may revoke this authorization but only in writing delivered to the clinic office manager. I understand that if I choose to revoke this Authorization, the revocation will not be effective for any uses and/or disclosures of my protected health information that have already been made in reliance on this Authorization.

Agree or Decline

Notice of Privacy Practices

By signing this form, I acknowledge that Pappas OPT has made its Privacy Notice available to me, which explains how my health information will be handled in various situations. I understand that I may discuss my concerns and/or any questions I have concerning this Privacy Notice with Pappas OPT Specialists representatives.

Communication: I authorize Pappas OPT to communicate with me via **Email** and/or **Text message**.

EMAIL: _____ **Cell phone number:** _____

Is the reason for therapy the result of an MVA or Work-Related Injury? ___ Yes, date _____ ___ No

Have you had other therapy this year? ___ Yes How Many? _____ ___ No

Have you had Home Health Care? ___ Yes If yes, D/C Date: _____ ___ No

Release of Information

I authorize the following individuals to receive information regarding my diagnosis, treatment, and billing:

Name	Relationship

Authorization

I acknowledge, as indicated by my signature below, that I have read and fully understand this consent form. By signing this form, I am acknowledging my understanding of the "Notice of Privacy Practices" and authorizing persons listed on the Information Release to receive my health information.

Patient/Guardian Signature – (relationship to patient) _____
Date



Name: _____

Date: _____

Check-In COVID-19 Medical Form

*Have you recently visited an area of widespread or ongoing community spread of COVID?

___ Yes ___ No If yes, where _____

*Have you had direct contact with someone who has a confirmed or suspected case of coronavirus?

___ Yes ___ No

*Do you currently have any of the following symptoms?

- | | |
|---|----------------------------------|
| ___ Shortness of breath or difficulty breathing | ___ Cough |
| ___ Fever | ___ Repeated shaking with chills |
| ___ Chills | ___ Headaches |
| ___ Muscle pain | ___ New loss of taste or smell |
| ___ Sore throat | |

Signature _____ Date _____

CANCELLATION AND NO SHOW POLICY

In order to maintain efficient patient scheduling, we have a CANCELLATION / NO SHOW policy for our office. Your scheduled appointment is reserved for you, so if you are unable to keep your appointment, you must cancel at least (24) twenty-four hours in advance by direct communication with our office staff or voicemail service. Any missed appointment without a call will be considered a no-show. **A \$75.00 fee will be charged for all no-show and missed appointments not cancelled with a 24 hour notice and this fee must be paid at your next scheduled visit. If there are more than 2 cancellations with less than 24 hours notice in a month, you may not be able to schedule additional visits.**

If you are going to be late for your appointment, you should call to inform us of your expected time of arrival. **Your appointment may need to be re-scheduled at the discretion of the therapist.** This policy is to ensure that your late arrival will not interfere with the treatment of the patient scheduled after you.

I have read and understand the Cancellation/No Show Policy

Signature _____ Date _____