TEXAS PHYSICAL THERAPY SPECIALISTS

Physical Therapy Medical Screening

Date: ____/____/____ **DOB:** ____/____/____

Name: _____

Sex: M F Age:_____ Ht: _____ Wt:_____

Smoker: Y N Possibly Pregnant? Y N

Occupation:

Briefly describe your regular exercise routine:

Past Surgical History (please include dates if known):

_____

_____

Current Medications (please list or provide a list to photocopy):

_____

_____

_____

Recent diagnostic imaging (MRI, XR, CT) or blood work for current symptoms:

Past Medical History: **Please 1) Put a line through any condition you have NEVER had, and 2) Circle each condition you currently have OR ever had in the past.**

Cancer Diabetes I or II Stroke Blood Clot Pacemaker Depression Seizures Ulcers
High Blood Pressure Heart Disease Liver Disease Kidney Disease Lung Disease Asthma
Fibromyalgia Osteoporosis Osteoarthritis Rheumatoid Arthritis Allergies: _____
Other(s): _____
Recent illness? (explain): _____

Recently I have been experiencing (please circle all that apply, AND put a line through any that do not):

Fever/Chills/Sweats Unexplained weight loss Increased pain at night/rest Difficulty swallowing
Difficulty speaking Dizziness Poor balance/Falls Vision changes Numbness or Tingling
Nausea/Vomiting Chest Pain Shortness of breath Changes in appetite Pain with meals
Unusual pain with menstruation Change in (Bowel) or (Bladder) control, habits or appearance

CURRENT SYMPTOMS

Where is your PRIMARY symptom located?_____
Approximately what date did this symptom begin? _____
How did your symptoms start (injury/gradual/sudden)?_____
Have you ever had this problem before? (circle one: **Y N**) **If yes**, please answer the next two questions:
What treatments helped?_____
What treatments failed?_____

Please indicate any barriers to learning: _____

In the past month, have you often been bothered by feeling down, depressed, or hopeless? YES NO
In the past month, have you often been bothered by little interest/pleasure in doing things? YES NO
Are these feelings, something with which you would like help? (Yes today) (Yes but not today) (No)

I certify that the above information is correct (patient/guardian signature): _____ Date:_____
Reviewed by (physical therapist signature): _____Date: _____

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Consent to Treatment

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.
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.
3. 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.
4. Worker's Compensation - I hereby authorize Texas Physical Therapy I to receive my records related to my work injury.

Photo/Video Authorization

I grant to Texas Physical Therapy Specialists 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 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 Texas Physical Therapy 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 Texas Physical Therapy Specialists representatives.

PT Benefits Provided by Your Insurance Company

I acknowledge that my physical therapy benefits have been explained to me to my satisfaction. I understand that I am ultimately responsible for any copays, deductible(s), and/or co-insurance. I acknowledge that I should contact a representative of Texas Physical Therapy Specialists if I do not understand my benefits, have questions regarding payment due, or if I am unable to provide payment for my services prior to receiving treatment. **I understand that the information provided regarding my insurance is an estimate and a quote of benefits and may not reflect the exact balance owed. I acknowledge that I am responsible for any balance not covered by my insurance and that I have the right and responsibility to follow-up with my insurance for specific questions regarding my individual policy.**

Communication: I consent to receive information (such as appointment reminders, patient surveys, and other information relating to the physical therapy services provided to you) via the communication channels for which you provided the contact information including via phone, text, and email.

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 Name (please print):

_____

Patient or Guardian Signature:

_____

TexPTS Employee Signature:

_____

Date of Authorization: _____