Contact Information

Name: ___________________________________Date of Birth:___________________________

Contact Number:___________________________

Email: __________________________________

How Did You Hear About Transitions PT?____

I prefer to be contacted by:

[ ] Phone

[ ] Text Message

[ ] Email

New Patient Intake Form and Health History

Name: ____________________________________ Date of Birth__________________________

Age:_________________ Height:___________________ Weight:_________________________

Gender:________________________ Occupation:_____________________________________

Do You Exercise or Play A Sport?____

Please Describe Typical Frequency and Duration:______________________________________

How Long Have You Participate In Your Exercise Program or Sport?______________________

Are You Currently Able To Participate?____

Where Do You Participate?____

Other Hobbies:____

Reason For Your Visit:____

Injury Date or Onset of Symptoms:____

Have You Seen a Doctor For Your Symptoms?__________ If So, When? _________________

Did your doctor refer you to physical therapy?____

Doctor’s Name and Number:____

Have You Had Any Diagnostic Tests?
____

If So, When?____

Results:____

Have You Had Treatment For This Condition Before? ____________________________

Please Describe Treatments and Results:
____
____
____

Past Medical History:
____
____
____

Medications:
____
____
____

Terms of Acceptance and Consent To Treat

Informed Consent
A patient willfully choosing to be treated by Transitions Physical Therapy, Inc. gives Transitions Physical Therapy, Inc. permission and authority to care for him/her in accordance with physical therapy tests, procedures, and treatments. Physical therapy is usually beneficial and seldom causes any problems, and in rare cases, underlying physical defects, deformities and pathologies may render the patient susceptible to injury. Therefore in no way will the treating therapist provide services of any kind if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever it is he/she is suffering from; latent pathological defects, illnesses or deformities that would otherwise not come to the attention of the treating practitioner. The treating practitioner provides a specialized, non-duplicating health care service, and furthermore, any risk involved regarding physical therapy will be explained to you upon your request. Your treating practitioner is licensed in a special practice and is available to work with other types of physicians, practitioners and providers in your health care regimen.

Acknowledgement and Consent to Treat
I have read and understand the terms outline above and consent to all necessary treatment as determined by Transitions Physical Therapy, Inc. I have reviewed the Notice of Privacy Practices (HIPAA) and have been provided and opportunity to discuss my right to privacy. I will be given a copy of the privacy practices upon request.

Print Name:________________________________

Signature:_________________________________Date:_____________________________

Consent to Evaluate and Treat a Minor:

I, _________________________________ being the parent or legal guardian of,

_________________________________ have read and fully understand the above terms of acceptance and hereby grant authorization for my child to receive Physical Therapy care.

Print Name:_______________________________
Signature:_________________________________Date:_____________________________

NO SHOW- CANCELLATION POLICY

Transitions Physical Therapy is committed to helping you manage and maintain your health care needs. Our mission is to provide high quality care one patient at a time. When you schedule an appointment time with our Providers, that time is reserved for you. We do understand that on occasion unforeseen circumstances arise and the need to cancel your scheduled appointment may be necessary. If you know that your are unable to keep your appointment, we do ask that you notify our office of your need to cancel. Providing 24 hour notice will allow us to offer that appointment time to another patient.

We understand life is busy and schedules can be complicated. To avoid missed appointments, Transitions Physical Therapy will assist you with a friendly appointment reminder a day or more prior to your scheduled appointment. Understandably, a $25.00 charge will be assessed for "No Showing" or failing to give adequate notice of the need to cancel or reschedule.

I have read and understand the terms of Transition Physical Therapy No Show-Cancellation Policy. I understand I may be responsible for a $25.00 charge.

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Signature

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Date