



Today's Date: _____ **Social Security#:** _____

Full Name: _____

Date of Birth: ____/____/____ **Age:** _____ **Sex:** Male Female

Permanent Address: _____

City, State, Zip: _____

Home Phone: _____ **Alt. Phone:** _____

Referring MD: _____ **Primary Care MD:** _____

What is your Diagnosis(what will we be seeing you for?) _____

Whom may we thank for referring you to TTS? _____

What type of Insurance do you have? _____

Policy/ID# _____ **Grp#** _____ **Phone#** _____

Would you like to receive informational e-mails from TTS? (Check one)

YES. I would like to receive informational emails from TTS regarding Health and Wellness tips, Appointment confirmations etc. My information will NOT be sold or released any other entity other than TTS. I can be removed from this list at any time by my request. My e-mail address is: _____

NO. I do not wish to receive any email communications from TTS.

With whom do you live? (Check all that apply)

Alone Spouse Child/Children Other: _____

Current Employment (Check all that apply)

Working Full-time Working Part-time Retired
 Student Unemployed Other: _____

Living Environment (Check all that apply)

Stairs Ramps Elevator Assistive Devices (i.e. Grab-bars)



Assistive Devices (Check all that apply)

- Cane
- Walker
- Manual Wheelchair
- Power Wheelchair
- Glasses
- Other: _____

Past Medical History (Check all that apply)

- Arthritis
- Broken Bones/Fractures
- Osteoporosis
- Blood disorders
- Circulation/vascular problems
- Lung Problems
- Heart Problems
- High Blood Pressure
- Stroke
- Diabetes
- Low Blood Sugar
- Head Injury
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's
- Seizures/Epilepsy
- Developmental Problems
- Allergies
- Thyroid Problems
- Infectious Disease
- Cancer
- Kidney Problems
- Repeated Infections
- Depression
- Skin Diseases
- Ulcers/Stomach Problems
- _____

Within the past year, have you had any of the following symptoms?

- Chest Pain
- Heart Palpitations
- Cough
- Shortness of Breath
- Dizziness/Blackouts
- Headaches
- Loss of Balance
- Coordination Problems
- Difficulty Walking
- Pain at Night
- Joint Pain or Swelling
- Difficulty Sleeping
- Loss of Appetite
- Nausea/Vomiting
- Difficulty Swallowing
- Bowel Problems
- Weight Loss/Gain
- Urinary Problems
- Fever/Chills/Sweats
- Hearing Problems
- Vision Problems
- Weakness in Arms or Legs
- Other: _____

Prescription Medications

What prescription medications do you take? _____

Non-Prescription Medications (Check all that apply)

- Advil/Aleve
- Ibuprofen
- Aspirin
- Tylenol
- Other _____

Have you ever had any kind of surgery? Yes No (Please describe)



Current Condition/Chief Complaint

Why are you seeking Physical Therapy? _____

What happened? _____

When did it happen? _____

Have you ever had this problem before? Yes No If yes, when? _____

Have you ever had Physical Therapy for this problem before? Yes No

What did you do for the problem? _____

Did the problem improve? _____

How long did the problem last? _____

Are you currently seeing anyone else for this problem? (i.e. MD, Chiropractor)

Do you have difficulty with any of the following? (Check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Bed Mobility | <input type="checkbox"/> Gait (walking) | <input type="checkbox"/> Up or Down Stairs |
| <input type="checkbox"/> Transfers | <input type="checkbox"/> On Level Ground | <input type="checkbox"/> On Uneven Terrain |
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Grooming | <input type="checkbox"/> Shopping |
| <input type="checkbox"/> Cooking | <input type="checkbox"/> Home Chores (vacuum) | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Standing from chair | <input type="checkbox"/> Sports |
| <input type="checkbox"/> Hobbies | <input type="checkbox"/> Picking up child | <input type="checkbox"/> Reaching High Shelf |
| <input type="checkbox"/> Writing a Letter | <input type="checkbox"/> Using Telephone | <input type="checkbox"/> Standing >15 min |
| <input type="checkbox"/> Sitting >15 min | <input type="checkbox"/> Other _____ | |

Exercise/Activities

Do you exercise beyond your normal daily activities and chores? Yes No

What do you do? _____

With whom? _____ How many days per week? _____

Are there any social or extracurricular activities that you enjoy? _____



Assumption of Risk

I understand that although Total Therapy Solutions, LLC (TTS) and its staff take precautions to safeguard my health and safety, serious and potentially debilitating injuries can and do occur while participating in physical activity. I know that it is extremely important that I consider and be ever mindful of the risks that are involved in such activities as Physical Therapy and/or Personal Training/Wellness. I feel comfortable with and accept these risks and hereby release TTS and all of its staff from any and all liability.

INITIAL: _____

Consent to Receive Medical Care

I give authorization to Total Therapy Solutions, LLC (TTS) and/or its staff and agents to evaluate and treat me during my participation and the TTS facility (this includes immediate First Aid and treatment, physical exam, follow-up care, exercise, and rehabilitation). I understand that any TTS staff has the authority to prevent me from further participation because of an injury and/or because of any undue liability to TTS.

INITIAL: _____

Health Insurance Portability and Accountability Act Release (HIPAA)

I have read and fully understand the Notice of Privacy Practices. I may request a copy of the Notice of Privacy Practices at any time and hereby give Total Therapy Solutions, LLC (TTS) to release my medical information for purposes of billing and medical consultation.

Attendance Policy

I understand that I am responsible for my appointed times and will give 24 hour notice for cancellation or be subjected to a \$25 cancellation fee.

INITIAL: _____

PRINTED NAME: _____

SIGNATURE: _____ **DATE:** ___/___/___

In case of an emergency, please contact the following individual:

Name: _____ **Relation:** _____ **Phone #** _____