FOR OFFICE USE ONLY

**Name:** _____ **DOB:** _____ **Date:** _____
**Address:** _____ **City:** _____ **Zip:**_____
**Phone:** _____ ❑ **home** ❑ **mobile** | **Secondary Phone:** _____ ❑ **home** ❑ **mobile**
**Email address:** _____
**How would you like to receive appointment reminders?** ❑ **Text** ❑ **Automated Call** ❑ **Email**
**How did you hear about us?** _____

❑**By checking this box and providing my mobile number, I consent to receive SMS from Cadence Physical Therapy. Reply STOP to opt-out; For assistance Reply HELP; Message and data rates may apply; Messaging frequency may vary.** https://cadence-pt.com/terms-of-service-for-sms-communications/

**Primary Insurance Policy Holder (if not you) Name:** _____ **DOB:** _____
**Primary Insurance:** _____ **Secondary Ins:** _____ **Tertiary Ins:** _____
**Primary Care Physician:** _____ **Return to MD:** _____ (MM/DD/YYYY)

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**Age:**_____ **Height:** _____ **Weight:** _____
**Do you exercise regularly? If so, what type?** _____
**Occupation, including activities required for your job:** _____
_____
**Are you on a work restriction from your doctor?** ❑ Yes ❑ No
**FOR WOMEN: Are you currently pregnant or think you might be pregnant?** ❑ Yes ❑ No

**What are we seeing you for today?** _____
**What date (roughly) did your present symptoms start?**_____
**What do you think caused your symptoms?** _____
**Your 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)** _____
_____

**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 week:** _____
**The worst your pain has been during the past week:** _____

**Do you currently receive any home health services?** ❑ **Yes** ❑ **No**
**If yes, which of the following home health services do you receive? (Please select all that apply)**
❑ **Nurse** ❑ **Physical Therapist** ❑ **Occupational Therapist** ❑ **Speech Therapist**
❑ **Other (Please specify)** _____

**Please provide the name and contact information of the agency or individuals providing these services:**
**Name:** _____ **Contact Information:** _____

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

❑ fatigue
❑ fever/chills/sweats
❑ nausea/vomiting
❑ cough
❑ difficulty maintaining balance while walking
❑ changes in bowel or bladder function
❑ numbness or tingling
❑ muscle weakness
❑ dizziness/lightheadedness
❑ heartburn/indigestion
❑ difficulty swallowing
❑ _____
❑ weight loss/gain
❑ headaches
❑ shortness of breath
❑ fainting
❑ cough
❑ _____

**Have you or a close family member EVER been diagnosed with any of the following conditions (check all that apply to you and circle those that apply to your family history)?**

❑ cancer
❑ heart problems
❑ chest pain / angina
❑ asthma
❑ rheumatoid arthritis
❑ other arthritic condition
❑ bladder / urinary tract infection
❑ chemical dependency (i.e., alcoholism)
❑ sexually transmitted disease / HIV
❑ depression
❑ lung problems
❑ osteoporosis
❑ multiple sclerosis
❑ epilepsy
❑ stroke
❑ anemia
❑ bone or joint infection
❑ pelvic inflammatory disease
❑ thyroid problems
❑ diabetes
❑ high blood pressure
❑ circulation problems
❑ blood clots
❑ ulcers
❑ kidney problem/infection
❑ hepatitis
❑ liver problems

**ALLERGIES: Skin (latex) or medication(s):** _____

_____

**Please list any surgeries, and or medical conditions for which you have been hospitalized, including dates:**

1. _____ 2. _____ 3. _____
2. _____ 3. _____ 4. _____
5. _____ 6. _____ 7. _____

Emergency Contact Information:

Name of contact: _____ Relationship: _____

Primary Phone #: _____Work Phone #: _____

Patient Signature: _____ Date: _____

**Therapist Notes:**

_____

_____

_____

_____

**Patient Consent**

**Please initial next to each patient consent statement.**

____ I hereby consent to physical therapy treatment as prescribed by my physician, or as deemed necessary by the treating physical therapist. I also understand that physical therapy treatment, by its nature, involves inherent and unavoidable risks, including falls, and other similar injuries, and that the only alternative to entirely avoid these risks would be to forego physical therapy all together.

_____ I understand I am responsible for charges incurred, regardless of insurance coverage. If Cadence Physical Therapy Co has a contract with your insurance carrier, we will file the claim. If the insurance company denies payment for no referral, non-covered services, deductible, etc, I am responsible for all balances due.

_____ I assign all benefits to Cadence Physical Therapy Co that are received from my insurance provider for physical therapy services rendered.

_____ It is advised that a parent or guardian attend all sessions with patients that are **minors** and I waive any claim that I may have due to my failure to comply with this advisement.

_____ I understand that Cadence Physical Therapy Co takes all actions available to keep my personal information private. I have received the Notice of Privacy Practices from Cadence Physical Therapy Co.

**48 Hour Notice Cancellation Policy**
**Automatic Balance Charge**
**Credit Card Required**

A cancellation fee of **$50.00** will be charged for each appointment that is cancelled with less than **48-hour** notice. A credit card is required to be on file in the event of a short notice cancellation. This fee is waived if you make up the visit, within the same calendar week.

**Cancellations impact 3 individuals**:
1) Yourself – You limit your ability to reach your goals
2) Your Provider – Time has been made in the provider's schedule specifically for you
3) Another patient – We are unable to fill your appointment slot with others that are needing to get on the schedule when short notice is given.

By signing below, I agree to a $50.00 cancellation fee to be charged to my credit card on file if less than 48 hours' notice is given for my scheduled appointment.

**Automatic Balance Charge**:

By signing below, I agree that the balance on my account will be charged to my card on file at the end of the month. Cadence Physical Therapy Co will give you notice before the charge is made and the opportunity to call and make other arrangements or ask questions, if needed.

Name on Credit Card  Last 4 Digits on Card  CVV  Billing Zip

Email  Signature  Date

I certify that all information provided to Cadence Physical Therapy Co is correct.

Patient/Legal Guardian Signature  Date