HOLISTIC
PHYSICAL THERAPY
6225 FM 2920, Suite 130, Spring, Texas 77379

PATIENT INFORMATION

Is this a **MOTOR VEHICLE ACCIDENT** related? If **YES**, please see the receptionist before moving forward with this paperwork.

How did you hear about us?: □ My Doctor □ Online □ Friend □ Event

Name: _____ Sex: [ ]M [ ]F

Address: _____ Date of Birth: _____

City: _____State: _____ Zip: _____ Social Security #: _____

Employee #: _____

Home Phone: _____ Marital Status: [ ] Married [ ] Single

Cell Phone: _____ Referring Physician: _____

Email Address: _____ Primary Care Physician: _____

PATIENT EMPLOYMENT

[ ] Employed [ ] Retired [ ] Not Employed

Employer:_____

Phone: _____

EMERGENCY CONTACTS (NAME & PHONE)

_____

_____

_____

Medical Insurance Primary Subscriber's Information

[ ] I am the primary subscriber
[ ] I am NOT the primary subscriber (if checked, **please fill out below**)

Name: _____ Date of Birth: _____

Relation to Patient:_____ Phone: _____

Address: _____

City, State, & Zip: _____

I understand that this form must be completed in its entirety. I understand that if all of the above information is not completed, a claim may not be able to be filed to my insurance company; therefore, making me fully responsible for any charges incurred.

Patient/Responsibility Party Signature: _____

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CONDITIONS OF SERVICE

PATIENT_____DOB_____ACCT#_____

Assignment of Benefits

I, or authorized representative/legal guardian acting on behalf of the patient hereby authorize payment of insurance benefits under the terms of my policy directly to Holistic Physical Therapy, LLC and/or Spring Family Clinic, Dr. Sushma Gorrela for services rendered. I am financially responsible and will pay for charges not covered by my insurance plan.

X_____ _____
Patient/Guarantor Signature **Date**

Financial Agreement and Statement of Responsibility

For and in consideration of services rendered or to be rendered the facility, I agree to pay said clinic for all services and charges. I understand that I am responsible for any health insurance deductibles, coinsurance and non-covered charges. **I understand payment in full is due at the time services are rendered or payment arrangements are to be made before my appointment. I understand that the amount quoted by the facility as being my responsibility is an estimate only and any patient balance remaining after my insurance has processed my claim will be billed to me and due within 30 days.**

I understand that it is my responsibility to inform the office with a minimum of a 24 hour advance notification if I am unable to make any appointment. I understand that I will be charged a fee of $50 for not giving proper notification.

X_____ _____
Patient/Guarantor Signature **Date**

Consent to Medical Treatment by Physical Therapist

I, or authorized representative/legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services, which may include routine diagnostic procedures and such medical treatment as the Physical Therapist, his/her Physical Therapy assistants or his/her designees consider to be necessary in his/her judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to results of treatment or examination at the facility.

X_____ _____
Patient/Guarantor Signature **Date**

Acknowledge of Review of Privacy Practices

I, the undersigned, have reviewed the Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of the Privacy Practices.

Release of Patient Healthcare Information

I hereby authorize the facility and any subcontractor of, **to release or obtain** patient healthcare information, including but not limited to reports, prior films/images, in accordance with the policy of the clinic, as is necessary to health care providers to facilitate reimbursement by a health benefit plan or personnel of another health care entity for the purpose of providing current continuum of care including to facilitate reimbursement by a health benefit plan or third party payor, including but not limited to, my insurance carrier, Medicare, Medicaid, and any other payer or agency.

X_____ _____
Patient/Guarantor Signature **Date**

Do you have an advanced directive(living will)? _____**YES** _____**NO**
If yes, please bring a copy into our office for our files.
If no, and you would like information on advanced directive, please speak with your physician,

The above authorizations are valid unless you revoke them in writing.

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CONDITIONS OF SERVICE

Massage Therapy Waiver and Consent Form

Because massage is contraindicated under certain conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the massage therapist's part should I forget to do so.

X_____ _____

Patient/Guarantor Signature **Date**

Consent to Myofascial Trigger Point Therapy

It is imperative to be aware that Trigger Point Therapy will not be complete in just one session. During a normal and routine muscle trigger point therapy session pain and/or bruising may occur, it is important that swelling and stiffness will not leave in just one session. Each case is different and for best results, it is wise to expect several treatments to relieve and remove the pain. After several therapy sessions, many see improvements in mobility and that less tension is experienced. It is normal to feel muscle soreness after receiving physical therapy. If the soreness does not resolve after 24 hours, it is recommended that you see the physical therapist the next day for further intervention.

X_____ _____

Patient/Guarantor Signature **Date**

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Medical History Questionnaire

Name: _____

Date of Birth: _____ **Sex:** M F **Phone:** _____

Do you have the following:	Yes	No
1. Physical Therapy Prescription or Order		
2. Imaging Reports		
3. Surgical Reports		
4. Physician Office Visit Notes – Medical Diagnosis		
5. Previous or Past Rehabilitation Records		

What body part is affected / in pain? _____

Which side? LEFT RIGHT

Hand Dominance? LEFT RIGHT

How did this pain happen? SUDDEN FALL SPORTS

CAR ACCIDENT WORK INJURY CHORES

OTHER: _____

Has the pain / injury happened before? YES NO

If YES, how long ago? _____

Are you currently seeing a Doctor / Medical Professional for this condition? YES NO

If YES, then who? _____

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Medical History Questionnaire

Name: _____

Date of Birth: _____ **Sex:** M F **Phone:** _____

Please list the symptoms that brought you here today. Mark them on the body diagram as:

P = pain, N = numbness, T = tingling and W = weakness

Please list the date the symptoms started and if any previous episodes of pain. _____

_____

Please list current/previous medical conditions: _____

_____

Please list any previous surgeries: _____

_____

Please list diagnostic tests recently performed (X-Rays, MRI, CT scan, and PET): _____

_____

Please list current medications: _____

_____

What makes your symptoms worse? _____

What makes your symptoms better? _____

Are symptoms worse in the morning, evening, at night or as the day progresses? _____

_____

How long can you sit and/or stand before symptoms increase? _____

_____

Does pain wake you after you fall asleep? (Please circle) YES NO

If YES, how many times? _____

What position(s) do you sleep in? (Please circle more than one if applicable)

BACK STOMACH LEFT SIDE RIGHT SIDE

What type of sleeping surface do you have? (Please circle)

FIRM SOFT SAGGING WATERBED

If employed, what is your occupation? _____

Job Requirements: _____

_____

Current work status: (Please circle)

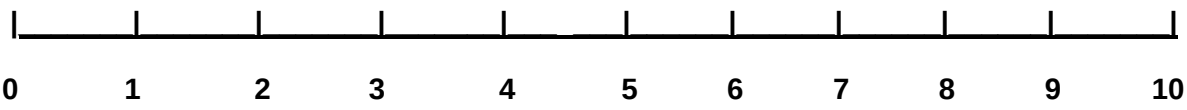
FULL DUTY LIGHT DUTY FULL TIME PART TIME OFF WORK DUE TO INJURY

Do your symptoms limit normal activities of daily living? Please describe. (Cleaning, vacuuming, sweeping, dressing, showering/bathing, yard work etc.) _____

_____

Please mark on the line below to indicate your pain levels over the last three (3) days with the following:

L= least pain A = average pain C = Current pain W = worst pain



0 1 2 3 4 5 6 7 8 9 10

(No Pain) (Extreme Pain)

Please list at least two (2) goals that you hope to accomplish by participating in physical therapy:

_____

_____

When is your next follow – up appointment with your physician? _____