EVOLVE
PHYSICAL THERAPY

To provide you with the best possible service, please provide the following information.

Patient Information

Name: _____ Date of Birth: _____/_____/_____

Assigned gender at birth: ☐ Female ☐ Male Preferred Pronouns: ☐ She / Her ☐ He / Him ☐ They / Them

Address: _____ City: _____ State:_____ Zip: _____

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____ Email: _____@_____

Emergency Contact:_____ Relationship: _____ Phone: (____) _____-_____

Primary Care / Referring Physician:_____ Surgeon: _____

Have you been treated by another physical therapist this year? ☐N ☐Y If yes, how many visits? _____

Who may we thank for referring you to us, or how did you hear about us? _____

Parental / Guardian Information *(only for patients under the age of 18)*

Name of Persons Responsible for Account: _____ Date of Birth:____/____/_____

☐ Check if address is the same as patient's address, otherwise please provide the following:

Address: _____ City: _____ State:_____ Zip: _____

Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Other_____ Employer: _____

Work Phone: (____) _____-_____ Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____

Authorization for Release of Information to Family Members

Many of our patients allow family members to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Evolve Physical Therapy to release my medical and/or billing information to the following individuals:

1)_____ Relation to Patient:_____

2)_____ Relation to Patient:_____

3)_____ Relation to Patient:_____

Please initial:

_____ I authorize Evolve Physical Therapy to leave detailed voicemails on my cell phone

_____ I authorize Evolve Physical Therapy to send me text messages on my cell phone

Current Injury / Problem: _____ **Date of injury/surgery:**_____

What are your LOWEST and HIGHEST pain levels? *(please circle two)*

0 1 2 3 4 5 6 7 8 9 10

Have you ever been diagnosed with any type of the following conditions? (Check all that apply)

Have you fallen in the past 12 months? ☐N ☐Y

- ❑ Cancer (type) _____
- ❑ High blood pressure
- ❑ Heart disease
- ❑ Asthma
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Anemia
- ❑ Stroke / CVA
- ❑ Depression
- ❑ Rheumatoid arthritis
- ❑ Chemical dependency
- ❑ Lung problems
- ❑ Thyroid: Hyper / Hypo
- ❑ Diabetes Type II / Type I
- ❑ Multiple sclerosis
- ❑ Kidney / liver disease
- ❑ Stomach ulcers
- ❑ Epilepsy
- ❑ Parkinsons
- ❑ Allergies
- ❑ Other_____

Have you recently experienced any of the following?

- ❑ Nausea / vomiting
- ❑ Dizziness / lightheadedness
- ❑ Difficulty maintaining balance
- ❑ Difficulty swallowing
- ❑ Fever / chills / sweats
- ❑ Weight loss / gain
- ❑ Shortness of breath
- ❑ Changes in appetite
- ❑ Pain at night
- ❑ Weakness / fatigue
- ❑ Urinary or bowel problems
- ❑ Headaches

Current Medications,dosage & supplements: *(☐ copy of list provided)* _____

_____

Are you currently taking any blood thinning medications? ☐N ☐Y _____ **Do you smoke?** ☐N ☐Y PPD_____

Females: Are you currently pregnant or planning on becoming pregnant? ☐N ☐Y

Please list any prior surgeries or hospitalizations:

_____

_____

What clinical tests have you had relating to your current condition? ☐X-ray ☐MRI ☐CT-Scan ☐Bone Scan ☐Other

Location: _____

Please list the activities or positions that are most limiting due to your condition:

_____

_____

Consent for Care and Treatment:

I, the undersigned, do hereby agree and give my consent for Evolve Physical Therapy to furnish medical care and treatment, including telehealth, to me (or my child) considered necessary and proper in diagnosing and/or treating my (or my child's) condition. I acknowledge that I have been offered a copy of Cancellation / No Show Policy and HIPAA Privacy Practices of Evolve Physical Therapy and agree to the terms therein.

X_____ ____/____/_____

Signature of Patient *(Parent if Patient is a Minor)* Date