HAAS PHYSICAL THERAPY & WELLNESS

PATIENT INFORMATION

Name ____ Date of Birth ________________ Age ________
Email ____
Phone: Mobile (   ) ______-__________ Work (   ) ______-__________ Home (   ) ______-___________
Address ____
City ____ State _________ Zip Code _________________
Preferred Method of Contact: ☐ email / phone: ☐ mobile ☐ work ☐ home

Referred by ____
Occupation/Sport ____

PARENT/GUARDIAN INFORMATION ☐ N/A

Name ____ Relationship to Patient _______________________
Phone: (   ) ______-____________ Email ____
Address ____ City ________________ State _____ Zip _________
Parental Consent for Treatment: As parent and/or legal guardian of __________________________________,
I authorize Nicole Haas, PT, DPT, OCS to treat while I am not present.
Parent/Guardian Signature: ____ Date __________________

EMERGENCY CONTACT

Name ____ Relationship to Patient _______________________
Address ____ City ________________ State _____ Zip _________
Phone: (   ) ______-____________ Email ____

CURRENT INJURY HISTORY

What issue(s) are you coming to PT for? ____
When did the injury or symptoms first appear? ____
How did the injury/symptoms occur?____
____
What are your current symptoms (pain/burning/numbness ache) and where are they on your body?_____________
____
Please list your level of pain using a scale of 0 – 10 (0= no pain, 10= unbearable pain)

Current ____ /10 At it's worst ____ / 10 At it's best ____ /10

Did you have x-rays/MRI/CT scan of this body part? If yes, please indicate findings _______________________
____
Have you had surgery for this condition and when? ____
____

Patient's Signature: ____ Date _______/_______/_______
Parent / Guardian Signature (if applicable) ___________________________ Date _______/_______/________

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GENERAL HEALTH HISTORY

To ensure that you receive a thorough and complete evaluation, please provide us with important background information on this form. If you are unclear regarding any of these questions, please leave it blank and your therapist will assist you.

Do you currently have or have you ever had any of the following?

Are you pregnant? ☐ N/A	☐ yes ☐ no	Hypoglycemia	☐ yes ☐ no
Diabetes	☐ yes ☐ no	Headaches	☐ yes ☐ no
High Blood Pressure	☐ yes ☐ no	Fevers/chills/sweats	☐ yes ☐ no
Heart Disease	☐ yes ☐ no	Unexplained weight loss/gain	☐ yes ☐ no
Heart Attack/ Pacemaker	☐ yes ☐ no	Malaise (feeling generally unwell)	☐ yes ☐ no
Kidney Problems	☐ yes ☐ no	Unusual fatigue	☐ yes ☐ no
Cancer	☐ yes ☐ no	Nausea/Vomiting	☐ yes ☐ no
Osteoporosis	☐ yes ☐ no	Numbness/tingling	☐ yes ☐ no
Asthma/Breathing Difficulties	☐ yes ☐ no	Unexplained weakness	☐ yes ☐ no
Liver/Gallbladder Problems	☐ yes ☐ no	Dizziness/light headedness	☐ yes ☐ no
Hernia	☐ yes ☐ no	Fainting/ loss of consciousness	☐ yes ☐ no
Seizures	☐ yes ☐ no	Difficulty breathing/shortness of breath	☐ yes ☐ no
Metal Implants	☐ yes ☐ no	Chest pain/palpitations	☐ yes ☐ no
Recent Fractures	☐ yes ☐ no	Swelling in feet or hands	☐ yes ☐ no
Surgeries	☐ yes ☐ no	Difficulty with swallowing	☐ yes ☐ no
Rheumatoid Arthritis	☐ yes ☐ no	Unexplained change in appetite	☐ yes ☐ no
Stroke/CVA	☐ yes ☐ no	Unexplained bowel/ bladder changes	☐ yes ☐ no

If yes to any of the above, please briefly explain and provide approximate date ______________________________

____

Do you have any other medical issues or previous medical conditions not mentioned above?

____

____

Please list your current medications ____

Patient's Name ____

Patient's Signature ____ Date _______/_______/_______

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OFFICE POLICIES

Patient/Responsible Party Name: ____

Consent to Treatment

________ (initial) I give my consent for Nicole Haas, PT, DPT, OCS to treat my condition within the scope of practice defined by the American Physical Therapy Association, and to provide physical therapy care and treatment considered necessary and proper in evaluating and treating my physical condition. I understand that this consent is intended as a waiver of liability for such treatment excepting acts of negligence.

Notice of Privacy & Electronic Communication Policies

________ (initial) I understand that Nicole Haas, PT, DPT, OCS will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I also understand that electronic communication is the primary method for scheduling and exchange of my personal health information for the purposes of carrying out treatment, and acknowledge that I am aware that email is not considered a secure method of communication, and agree to the risks.

Payment for Services

________ (initial) I understand that Haas Physical Therapy & Wellness is a fee-for-service clinic. This means that payment is due at the time services are rendered and your insurance company (if applicable) is not billed. Upon request, receipts with diagnosis and treatment codes can be provided which may be submitted to your insurance company for reimbursement under "out of network benefits." Payment is accepted with cash, personal checks, and credit cards via Square Processing, and is separate from CrossFit Sanitas.

Cancellation/No Show Policy

________ (initial) I understand that there is a 24 hour cancellation policy and that I will be charged in full for all appointments that are not cancelled 24 hours in advance of the scheduled appointment time. I also understand that I will be charged in full if I fail to show up for my scheduled appointment as well.

Notice of Privacy Practices for Protected Health Information. Health Insurance Portability & Accountability Act of 1996 (HIPAA)

Due to increased awareness of the need for more strict guidelines regarding privacy of your protected health information, the Health Insurance Portability & Accountability Act of 1996 (HIPAA) was legislated, effective April 14, 2003. As part of this law, Nicole Haas, PT, DPT, OCS is required to provide you with the option of receiving a copy of this notice. You are able to receive this notice either electronically or on paper.

________ (initial) I am aware that this notice is available to me online at the clinic's website, www.HaasPhysicalTherapyandWellness.com, and I choose to receive such notice electronically or I have requested to receive a paper copy of the above. I understand that it is my responsibility to read and be aware of these rights as outlined in the Notice.