



Elite Physical Therapy & WELLNESS CENTER

Restoring optimal health through specialized care.

PATIENT INFORMATION

PLEASE PRINT. Fill in forms to the best of your knowledge. Leave blank if not applicable.

Today's Date: ____ / ____ / ____

Name _____ Soc. Sec.# ____ - ____ - ____
Last Name First Name Initial

Permanent Address _____ City _____ State _____ Zip _____

Temporary Address _____ City _____ State _____ Zip _____

Single Married Widowed Separated Divorced Student / Grade Level: _____ Sex M F (Circle One)

Birth date ____ / ____ / ____ Age _____ Home Phone Number: () ____ - ____ Cell Number: () ____ - ____

Email address _____

Date of Onset of Symptoms: ____ / ____ / ____ Chief Complaint: _____

Patient Employed by _____ Occupation _____

Employers Address _____ Employers Phone Number () ____ - ____

Referring Physicians Name _____ Date to return to Physician: ____ / ____ / ____

How did you hear about Elite Physical Therapy & Wellness Center? _____

Have you had any previous physical therapy or chiropractic treatments this year? _____

In case of emergency who should be notified? _____ Phone () ____ - ____
Name Relation to Patient

PRIMARY INSURANCE (STILL COMPLETE WITH CARD BEING GIVEN)

Name of Insurance Company _____ Insurance I.D.# _____ Group# _____

Policy Effective Date ____ / ____ / ____ Person Responsible for Acct _____

Relation to Patient _____ Birth date ____ / ____ / ____
Last Name First Name Initial

Address (if different from patient's) _____ Phone () ____ - ____

City _____ State _____ Zip _____

SECONDARY / ADDITIONAL INSURANCE

Name of Insurance Company: _____ Insurance ID # _____

Group # _____ Effective Date ____ / ____ / ____

Subscriber Name _____ Relation to Patient _____ Birth date ____ / ____ / ____

Address (if different from patient's) _____ Phone () ____ - ____

City _____ State _____ Zip _____

Subscriber Employed by _____ Phone () ____ - ____

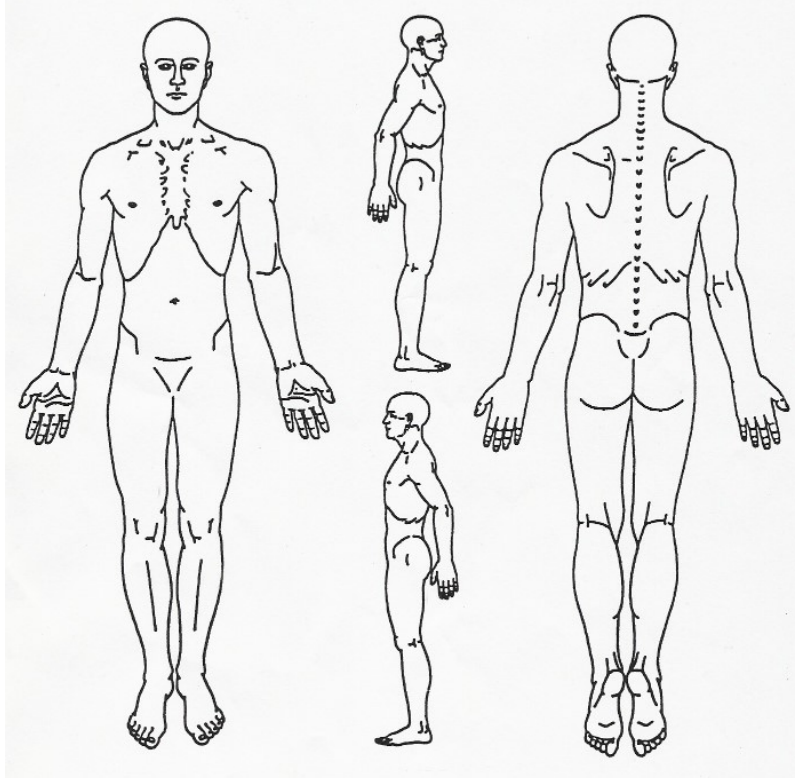
PAIN DRAWING

NAME: (please print) _____ DATE: _____

Mark the figures below using the letters that best describe your sensation or pain.

Use ↑, ↓, or ←, → to indicate the direction of radiating or referred pain.

A = Ache	B = Burning	R = Radiating Pain	D = Dull Pain
N = Numbness	S = Stabbing	P = Pins & Needles	O = Other



Please indicate how you would rate your pain (LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

If you have multiple areas of pain, write your pain rating next to the body part.

When did the pain begin? _____ Any flare-ups since then? _____ If so, when? _____
 What brought the pain on? _____
 Is the pain: constant intermittent
 If intermittent, how often does the pain occur? _____
 Does it interfere with: Work Sleep Daily Routine Recreation Other _____
 Which activities or movements cause pain?
 Sitting Standing Walking Bending Lying Down None Other _____
 When and what makes it feel better? _____
 When and what makes it feel worse? _____



PATIENT MEDICAL HISTORY AND PERSONAL FITNESS QUESTIONNAIRE

The following questionnaire is used to gather information regarding your current and past medical status. Responses to these questions will provide our staff with information required to help determine the safest and most effective treatment for you.

PERSONAL HISTORY

Check each as it applies to you. Have you ever had:

	YES	NO	UNSURE		YES	NO	UNSURE
Allergy				Kidney Problems			
Angina				Leg Cramps			
Arm Pain				Low Blood Pressure			
Asthma				Menstrual Irregularities			
Back pain				Metal Implants			
Blackouts				Motor Vehicle Accident(s)			
Bowel/Bladder Abnormalities				Nervousness			
Cancer				Night Pain			
Chest pain				Osteoarthritis			
Convulsions				Osteoporosis			
Depression				Paralysis			
Diabetes				Poor Tolerance to Heat/Cold			
Dizziness/Fainting				Recent Fractures			
EKG Abnormalities				Rheumatoid Arthritis			
Emphysema				Ringling in your ears			
Gout				Seizures/Neurological Disorders			
Headache				Severe Illness			
Heart attack				Sexual Dysfunction			
Heart Disease				Shortness of Breath			
Hernia				Skin Abnormalities			
High Blood Pressure				Sleep Interference			
Hospitalized				Stroke			
Indigestion/Nausea/Vomiting				T.B.			
Joint Problems				Ulcers			
Joint Sprains				COVID			

Have you ever had physical therapy or currently receiving **home health**? yes___ no___

If so, please explain:

Have you ever had any orthopedic injuries, sprains, strains, fractures, etc.? yes___ no___

If so, please explain: _____

Have you ever had surgery? yes___ no___ If so, what for?



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Any other medical problems? If so, please describe: _____

MEDICAL HISTORY

Name of your family physician _____

Date of last physical (approximately, if unsure) _____

Do you wear a pacemaker? yes___ no___

Do you know your resting blood pressure yes___ no___ _____ mmHg

Do you know your resting heart rate? yes___ no___ _____ BPM

Have you ever had an exercise ECG? yes___ no___

Are you pregnant? yes___ no___

Indicate any medications you are taking:

Please list all drug allergies:

I certify that to the best of my knowledge the above answers are true and accurate.

Signature

Printed Name

Date



COVID SCREENING

Name: _____

Date: _____

Have you traveled out of state or country or have been in close contact with anyone who has traveled within the last 14 days?

Yes _____ No _____

Have you had close contact with or cared for someone diagnosed with COVID-19 within the last 14 days?

Yes _____ No _____

Have you experienced any cold or flu-like symptoms in the last 14 days (fever, cough, shortness of breath or other respiratory problem)?

Yes _____ No _____

Have you ever been diagnosed with COVID 19?

Yes _____ When _____ No _____

Have you been fully vaccinated?

Yes _____ No _____ Partially _____

Signature: _____



CONSENT FOR TREATMENT (read carefully)

I recognize that I am suffering from a condition requiring physical therapy services and treatment. I hereby consent to the rendering of physical therapy services by Elite Physical Therapy and Wellness Center, as described to me or as my physician or Elite Physical Therapy and Wellness Center determines are necessary. I understand that the practice of physical therapy is not an exact science, and that physical therapy treatment involves the risk of injury or even death. I acknowledge that no guarantees have been made to me about the outcome of treatment.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign Elite Physical Therapy and Wellness Center (1) all insurance, Medicare, and other private or governmental benefits payable for my treatments and care; and (2) all rights to payment and all money paid for any claim related to physical therapy service and treatment. Anyone paying or receiving money for my benefits or claims shall pay the money directly to Elite Physical Therapy and Wellness Center for payments of my bills. I understand that I am financially responsible for all charges not covered by my insurance or other third party payers and that any balance after insurance or third party payment has been made is due within thirty (30) days.

I have read and understand this form and the program it describes, and I do voluntarily request the right to participate in Elite Physical Therapy and Wellness Center’s rehabilitation program. I do hereby discharge, release, and hold harmless Elite Physical Therapy and Wellness Center and any if it’s personnel participating in this rehabilitation program from any and all liability for damage of any kind or character resulting from any injury or condition that I may suffer, or may result from such a rehabilitation program.

CANCELLATION POLICY

KINDLY, GIVE AT LEAST 24 HOURS NOTICE FOR CANCELLATION OR RESCHEDULING. FAILURE TO GIVE 24 HOURS NOTICE WILL RESULT IN A \$50.00 CHARGE.

PLEASE BE TIMELY FOR APPOINTMENTS If you arrive more than 15 minutes late for your scheduled appointment, you may have to reschedule. This is for the benefit of you and other patients being treated.

WHEN ABLE, PLEASE SCHEDULE YOUR APPOINTMENTS ONE WEEK IN ADVANCE TO ENSURE THE TIME THAT YOU NEED. Appointment times given one week do not automatically follow through to the subsequent weeks.

PARTICIPANT SIGNATURE

DATE

PARENT OR GUARDIAN SIGNATURE

DATE

ELITE PT EMPLOYEE SIGNATURE

DATE



CONSENT OF DISCLOSURE AND ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE

(HIPPA Notice posted in waiting room)

I hereby give consent to Elite Physical Therapy and Wellness Center and all health care providers furnishing care within Elite Physical Therapy and Wellness Center to use and disclose my protected health information for the purposes of treatment, payment, and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address listed above. This may be delivered in person or by mail, but will only be effective when actually received. Your cancellation will not be effective to the extent that others or we have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclose of your protected health information for the purposes of treatment, payment, or health care operations. We are not required to grant your request, if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy by: 1) viewing the copy that is available in our waiting room, or 2) by going to our web site: www.eliteptandwellness.com

PARTICIPANT SIGNATURE

DATE

PARENT OR GUARDIAN SIGNATURE

DATE

ELITE PT EMPLOYEE SIGNATURE

DATE

CONSENT TO RELEASE INFORMATION Leave blank if not applicable.

I hereby give authorization to release information to the person listed below:

Print Name of Person: _____

Relationship: _____ Contact Number: _____

Signature: _____



Patient Information and Consent for Dry Needling as a Procedure
For the Assessment and Treatment of Myofascial Trigger Points and Tender Points

Dry Needling is not acupuncture but uses acupuncture needles to effect a change in myofascial restrictions. Myofascial trigger points and tender points which appear in soft tissue, and are painful sites, reflect abnormal nervous system activity associated with many neuro-musculo-skeletal conditions that are treated in our office. The procedure known as Dry Needling is an important tool for diagnosing, treating, and monitoring changes in myofascial trigger/tender points. During the procedure, a sterile, very thin, solid filament needle is inserted into tissue that may be associated with one or a number of your complaints. One or a number of needles maybe used, and the procedure may be performed during more than one office visit. The number of needles and the frequency of the procedure will depend entirely on your condition at each office visit. There may be some discomfort and little to no bleeding with this procedure. While an infection is an unlikely event with this procedure, whenever there is penetration of the skin, there is risk of infection. Other unlikely but possible events include fainting, soreness, pneumothorax (lung puncture). If you have a fear of needles, a genetic bleeding disorder, a history of a blood disorder that can be transmitted to another person, are regularly taking any blood thinning medication (for example, Coumadin or Warfarin), or are regularly taking any pain relievers containing ibuprofen, NSAIDS, aspirin or acetaminophen (for example, Tylenol, Advil, Aleve, or Bufferin), please inform your physical therapist.

___ I have a fear of needles.

___ I have a genetic bleeding disorder, or history of a blood disorder that can be transmitted to another person.
Please specify:

___ I am regularly taking pain relievers and/or blood thinners.
Please specify:

I have read this Patient Information and Consent carefully. ***I understand this procedure is not acupuncture*** and I have had an opportunity to ask questions and obtain any desired clarification, and I consent to having the procedure of Dry Needling performed on me.

Patient Name (Please print): _____

Patient Signature: _____ Date: _____

If patient is less than 18 years of age, a parent or legal guardian must sign.

Name of Parent/Legal Guardian (Please print): _____

Parent/Guardian Signature: _____ Date: _____



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Name: _____ Date: _____

Please let us know how you heard about Elite Physical Therapy and Wellness Center and who we may thank for referring you. Please be as specific as possible. Mark all that apply.

- Family/Friend (Please provide, their address or phone number so we may send them a thank you card)

- Referring Doctor's Name _____
- Athletic Trainer/School _____
- Sports Complex _____
- Other Therapist _____
- Hospital Name _____
- Worker Comp _____
- Employer _____
- I am a Previous Patient _____
- Internet/Web page Yahoo _____ Google _____ Other _____
- Close to home/work _____
- Insurance Plan _____