GILLETTE
PHYSICAL THERAPY

Date:________________

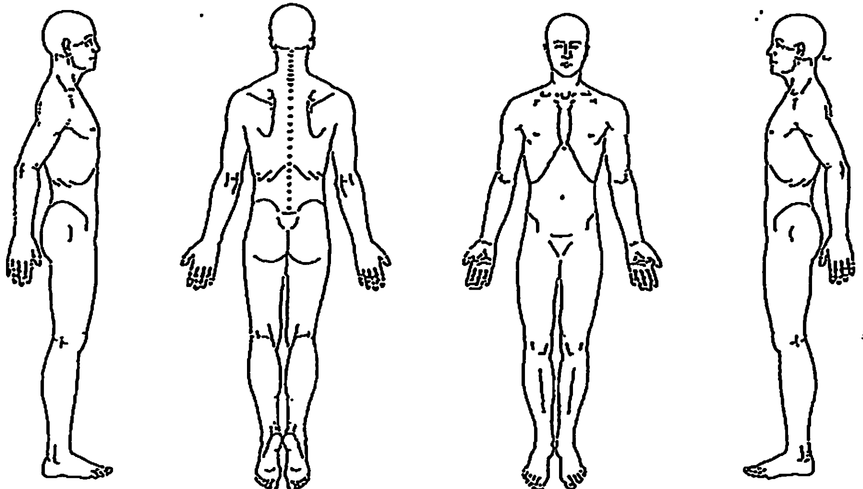
Full Name:____ DOB:__________________ Marital Status: S M D
Height:_______________ Weight: _______________ Are you currently working? Y N
Occupation:____ Employer:________________________________
Referring Provider: ________________________________ Next appt with referring provider: ______________
Have you had this condition in the past? If yes, please give details:____
Is this condition related to an injury/accident? Y N Date of Injury/Accident: ______________________
Description of injury/accident: ____
Have you had surgery for this condition? Y N Date of Surgery : ______________________________
Have you had any of the following related to this condition? (please circle)
MRI CT Scan X-ray Other:____________
Please circle ***which goals*** you wish to achieve from attending therapy.
Regain mobility Return to work Decrease pain
Regain previous level of activity Maintain independent daily living Other: ________________
Please circle all that apply to your current medical history.
High blood pressure Heart attack Pacemaker/stents Respiratory conditions
Diabetes: Type 1 or 2 Cancer Rheumatoid Arthritis Osteoarthritis
Weight loss Weight gain Incontinence Pregnant: Y N Week of gestation:__________
Are you currently taking any medications? If yes, please list below or provide a medication list.

Medication	Dosage	Frequency of Dosage

Considering the last 24hours, how would you rank your pain? *(0=None, 5=Moderate, 10=Extreme)*

Worst:	0	1	2	3	4	5	6	7	8	9	10
Current:	0	1	2	3	4	5	6	7	8	9	10
Best:	0	1	2	3	4	5	6	7	8	9	10

Please mark the area of involvement on the body diagram below.



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Signature of Patient or Guardian

OVER

Date: ______________________

Patient Name: ____

Health Insurance Portability and Accountability Act (HIPAA)

I have been made aware of the HIPAA policy that was effective April 28, 2014. I have been offered a copy of the policy. In addition, I am aware that the full HIPAA policy is framed and posted in the lobby at GPT. There are copies available if I choose to take one in the future. **I also understand that I am not allowed to take photos or videos during treatment where other patient's privacy may be compromised.**

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Signature of Patient/Parent

Cancellation Policy

Gillette Physical Therapy works tirelessly to provide our patients with one on one care to achieve their goals. In order for us to better assist you in maximizing your desired outcome, compliance to your scheduled appointments is strongly encouraged.

In attempt to accommodate all of our patient's schedules we require 24-hour notice. If cancellation with less than 24-hour notice or failing to show for an appointment, you may be charged $25. Please note that this a patient balance as insurance and worker's compensation do not pay for this charge.

By signing below, you acknowledge that you have been made aware of this policy.

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Signature of Patient/Parent

Payment Policy

Our office requires payment at the time service is rendered (except for Medicare, Medicaid, or Worker's Comp). If you have active insurance, a **weekly payment of $50** is required to put towards your out of pocket expenses. If you are unable to do so or you feel you are at 100%, please request to speak to billing **prior** to being seen to make alternate arrangements and have your account noted as such. It is the responsibility of the patient to see that this weekly payment is made before leaving from their appointment.

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Signature of Patient/Parent