



**LIMITLESS**  
Physical Therapy & Wellness

# Physical Therapy Medical Screening

DOB: \_\_\_/\_\_\_/\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Name: \_\_\_\_\_

Sex: M F Age: \_\_\_ Ht: \_\_\_ Wt: \_\_\_

Smoker: Y N Possibly Pregnant: Y N

Occupation: \_\_\_\_\_

Briefly describe your regular exercise routine:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Past Surgical History: (include dates if known)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Medication: (list or provide list to copy)

\_\_\_\_\_  
\_\_\_\_\_

Recent Diagnostic Imaging (MRI, XR, CT)  
or blood work for current symptoms:

\_\_\_\_\_  
\_\_\_\_\_

## Past Medical History:

(Put a line through any condition you have NEVER had, AND Circle each condition you currently have OR ever had in the past)

Cancer Diabetes I or II Stroke Blood Clot Pacemaker Depression Seizures  
Ulcers High Blood Pressure Heart Disease Liver Disease Kidney Disease Lung Disease  
Asthma Fibromyalgia Osteoporosis Osteoarthritis Rheumatoid Arthritis

Allergies: \_\_\_\_\_

Other(s): \_\_\_\_\_

Recent illness? (explain): \_\_\_\_\_

## Recently I have been experiencing:

(please circle all that apply, AND put a line through any that do not)

Fever/Chills/Sweats Unexplained weight loss Increased pain at night/rest Difficulty swallowing  
Difficulty Speaking Dizziness Poor balance/falls Vision Changes Numbness or Tingling  
Nausea/vomiting Chest pain Shortness of breath Changes in appetite Pain with meals  
Unusual pain with menstruation Change in (Bowel) or (Bladder) control, habits or appearance

## Current Symptoms:

Where is your PRIMARY symptom located? \_\_\_\_\_

Approximately what date did this symptom begin? \_\_\_\_\_

How did your symptoms start (injury/gradual/sudden)? \_\_\_\_\_

Have you ever had this problem before? (circle one: Y N ) If YES, please answer the next two questions:

What treatments helped? \_\_\_\_\_

What treatments failed? \_\_\_\_\_

Please indicate any barriers to learning: \_\_\_\_\_

In the past month, have you often been bothered by feeling down, depressed, or hopeless?	YES	NO
In the past month, have you often been bothered by little interest/pleasure in doing things?	YES	NO
Are these feelings something with which you would like help? (YES today) (YES but not today) (NO)		

I certify that the above information is correct (patient/guardian signature): \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by (physical therapist signature): \_\_\_\_\_ Date: \_\_\_\_\_



**PATIENT SUBJECTIVE QUESTIONNAIRE**

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Date \_\_\_\_\_

Reason for visit (low back pain, headaches, etc): \_\_\_\_\_ Date of injury: -----

Please indicate how your pain started:

- Trauma
- Motor Vehicle Accident
- Progressive
- Work Accident
- Pregnancy Related
- Sports Injury
- Surgery
- Chronic Pain (unsure of cause)
- Other (briefly explain) \_\_\_\_\_

Have you had Physical Therapy or Chiropractic treatments previously?  YES  NO

Have you had any of the following diagnostic studies?

	NO	YES	Date (year)	Where
Diagnostic X-Rays	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
CT Scan (computed tomography)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
MRI (magnetic resonance image)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

On the body diagrams mark and label your primary areas of concern:

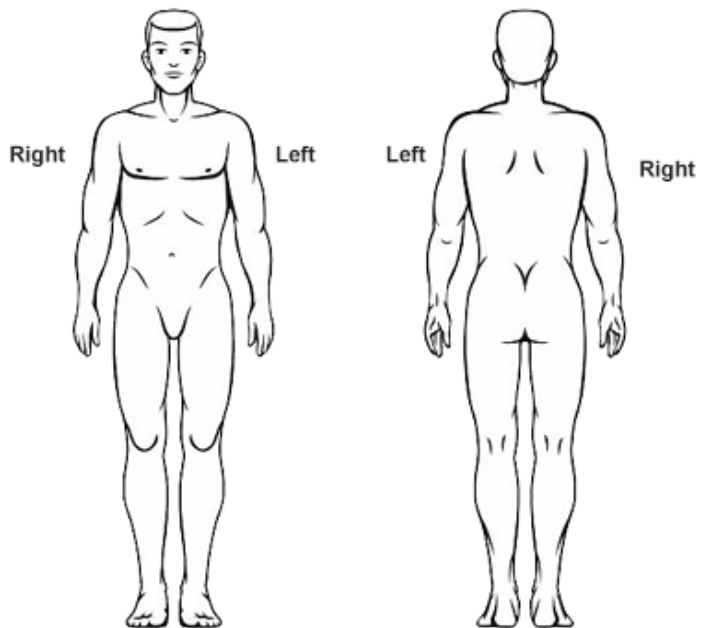
On the line below, please indicate (with an "X") the maximum and minimum amount of pain your feel on a daily basis:

No Pain-----Worst Possible Pain

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

What activities make your pain worse? (Please check (x) all that apply to you)

- Lying on back
- Bending forward
- Sitting
- Coughing / Sneezing
- Twisting
- End of Day
- Other \_\_\_\_\_
- Exercise (during)
- Bending backwards
- Exercise (after)
- Standing
- Early Morning
- Walking
- None



Initial \_\_\_\_\_



**Patient Name:** \_\_\_\_\_

1. Do you receive Veteran's benefits? Yes No
2. Are you receiving benefits under the Black Lung Program? Yes No  
 If yes, date benefits began \_\_\_\_\_  
 If yes, are the services you will be receiving related to a non-black lung condition? Yes No
3. Was this injury/illness due to a work related accident/condition? Yes No  
 If yes, date of injury/illness \_\_\_\_\_
4. Was this injury/illness related to an automobile accident? Yes No  
 If yes, date of accident \_\_\_\_\_
5. Was this injury/illness related to an accident which you intend to file a liability suit or litigation is pending? Yes No

Attorney Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_

**6. Are you entitled to Medicare based on:**

- Age (65 & over) – go to question 7
- Disability – go to question 7
- End Stage Renal Disease
  - Do you have group health plan (GHP) coverage? Yes No
  - Are you within the 30-month coordination period? Yes No

7. Are you currently employed? Yes No Date of retirement: \_\_\_\_\_
- a) Is your spouse currently employed? Yes No Date of retirement: \_\_\_\_\_
- b) Do you have a group health plan (GHP) as primary coverage based on your own or a spouse's current or former employment? Yes No
- c) Does the employer that sponsors your GHP employ 20 or more employees? Yes No

*If you answered Yes to questions #3, #4 or #7 above, please complete the following information:*

Insurance Company:	Address:
Policy/Cert. #:	Group Name and #:

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Responsible Party: \_\_\_\_\_

Relationship: \_\_\_\_\_



**Consent to Treatment:**

1. I have presented myself to this facility for therapy treatments and consent to the care (history, physical examination, treatment, etc.) that will be provided by my therapist.
2. I realize I have the right to refuse any treatments or procedures to the extent permitted by law. I acknowledge that the delivery of health care does not guarantee results of any treatments at this facility. I understand that information from any medical record(s) kept by this facility may be used for educational, administrative, and/or facility approved purposes when my personal identity will not be revealed.
3. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service. I am responsible for any services not covered by this authorization. I have read and fully understand the Patient Financial Responsibilities Form.
4. Worker’s Compensation - I hereby authorize Limitless Physical Therapy I to receive my records related to my work injury.

**PT Benefits Provided by Your Insurance Company:**

I grant to Limitless Physical Therapy and its affiliated entities, and its representatives and employees (collectively the “Company”) the right to take photographs and \or videos of me in connection with my participation in physical therapy services. I authorize the Company, to copyright, use and publish the same in print and/or electronically. I agree that the Company may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content and waive any right to compensation therefore. I understand that I may revoke this authorization but only in writing delivered to the clinic office manager. I understand that if I choose to revoke this Authorization, the revocation will not be effective for any uses and/or disclosures of my protected health information that have already been made in reliance on this Authorization.

Agree OR  Decline

**Notice of Privacy Practices:**

By signing this form, I acknowledge that Limitless Physical Therapy has made its’ Privacy Notice available to me, which explains how my health information will be handled in various situations. I understand that I may discuss my concerns and/or any questions I have concern-ing this Privacy Notice with Limitless Physical Therapy representatives.

**PT Benefits Provided by Your Insurance Company:**

I acknowledge that my physical therapy benefits have been explained to me to my satisfaction. I understand that I am ultimately responsible for any copays, deductible(s), and/or co-insurance. I acknowledge that I should contact a representative of Limitless Physical Therapy if I do not understand my benefits, have ques-tions regarding payment due, or if I am unable to provide payment for my services prior to receiving treatment. **I understand that the information provided regarding my insurance is an estimate and a quote of benefits and may not reflect the exact balance owed. I acknowledge that I am responsible for any balance not covered by my insurance and that I have the right and responsibility to follow-up with my insurance for specific questions regarding my individual policy.**

**Communication:**

I consent to receive information (such as appointment reminders, patient surveys, and other information relating to the physical therapy services provided to you) via the communication channels for which you provided the contact information including via phone, text, and email.

**Release of Information:**

I authorize the following individuals to receive information regarding my diagnosis, treatment, and billing.

Name	Relationship

**Authorization:**

I acknowledge, as indicated by my signature below, that I have read and fully understand this consent form. By signing this form, I am acknowledging my understanding of the “Notice of Privacy Practices” and authorizing persons listed on the Information Release to receive my health information.

**Patient Name (please print):**

\_\_\_\_\_

**Patient or Guardian Signature:**

\_\_\_\_\_

**Limitless PT Employee Signature:**

\_\_\_\_\_

**Date of Authorization:** \_\_\_\_\_

