



LIMITLESS

Physical Therapy & Wellness

Physical Therapy Medical Screening

Name: _____ DOB: ___/___/___ Appt. Date: ___/___/___

Address: _____ City: _____ Zip: _____

Preferred Phone: _____ Preferred E-mail: _____

Sex: M F Occupation: _____ (If Student: FULL Time PART Time)

Marital Status: _____ Social Security #: _____ - _____ - _____

How did you hear about us? _____

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? (YES NO) If YES, please answer the next two questions:

What treatments helped? _____

What treatments failed? _____

Past Medical History:

- 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:

- 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

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

PATIENT SUBJECTIVE QUESTIONNAIRE

Please indicate how your pain started:

- Trauma
 - Work Accident
 - Surgery (Date: ___/___/___)
 - Other (briefly explain) _____
 - Motor Vehicle Accident
 - Pregnancy Related
 - Chronic Pain (unsure of cause)
 - Progressive
 - Sports Injury
- Dates unable to work because of injury (if any): _____
- Dates of Hospitalization (if any): _____

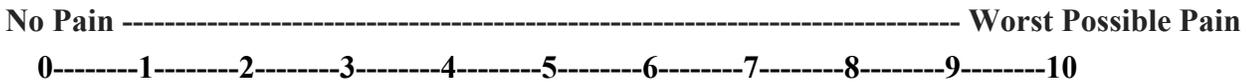
Have you received Physical Therapy this year? YES NO

Have you had any of the following diagnostic studies?

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

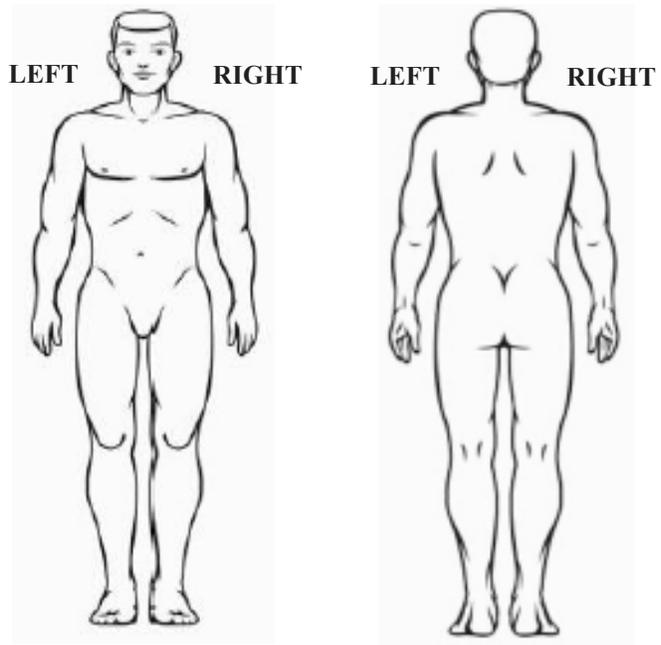
On the body diagrams mark and label your primary areas of concern:

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



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: _____

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 to receive my records related to my work injury.

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 concerning this Privacy Notice with Limitless Physical Therapy representatives.

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: _____

PT Benefits Provided by Your Insurance Company:

I acknowledge that my physical therapy benefits have been explained to me to my satisfaction. I understand 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 questions 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: |
|-------|---------------|
| _____ | _____ |
| _____ | _____ |

Patient Name: _____

1. Was this injury/illness related to an accident which you intend to file as a liability suit or litigation is pending?

- Yes No

If yes, please indicate:

Attorney Name: _____

Address: _____

Phone: _____

2. Are you currently receiving home health services?

- Yes No

Patient Name (Please Print): _____

Patient Signature: _____

Date: _____

Debt Collection Obligation:

I understand that in the event any unpaid balance is placed for collections with any third-party collection agency, a fee of 30% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, late fees, and any other fees so stated elsewhere. The authorized fee of 30% and the additional costs and charges listed above represent the actual costs incurred by Limitless Physical Therapy to collect amounts owed under this agreement and a corresponding decrease in expected revenue resulting from this signer's failure to pay as specified in this agreement.

Patient Name(please print): _____

Patient or Guardian Signature: _____

Limitless Representative: _____

Date: _____



Limitless Physical Therapy & Wellness Social Media Consent Form

I hereby give *Limitless Physical Therapy* permission to take photographs and videos of me for the purpose of posting on *Limitless Physical Therapy's* Facebook, Instagram, website and YouTube.

I hereby release and discharge *Limitless Physical Therapy* from any and all claims arising out of use of the Photos.

Limitless Physical Therapy has my permission to use: (Check one)

- Photos
- My first name
- Photos and my first name
- No Photo and name can be used

In signing this consent, I give authorization to use my name as printed below.

Patient's Name: _____

Patient's Signature: _____

Date: _____



Cancellation & No Show Policy

We understand situations arise in which you must cancel your appointment. It is therefore required that if you must cancel, give at least 24 hour notice. This will allow for another person that is waiting to be scheduled to take that time slot.

Patients that do not call to cancel their scheduled appointment will be considered as a NO-SHOW. Patients with three (3) No-Shows will be discharged from therapy.

As a courtesy to our valued patients, we do not charge a fee for cancellations or no-shows so please remember to be courteous and return the favor.

Late Policy

As a courtesy to others and their appointment times, We reserve the right to reschedule your appointment if you are more than 15 minutes late.

Patient's Name: _____

Patient's Signature: _____

Limitless PT Employee Signature: _____

Date: _____