

# PAST MEDICAL HISTORY

The purpose of this questionnaire is to help us understand your health status. Please complete this form and your therapist will answer any questions you may have during your exam.

**PATIENT NAME:** \_\_\_\_\_

Please circle if you have ever had:

## MUSCLE/SKELETAL:

Broken Bones/Fractures    Osteoporosis    Arthritis    Joint Pain/Swelling    Joint Replacement  
Weakness or swelling in arms or legs    Difficulty walking    Joint/Extremity/Spine surgery  
Back pain

## HEART/VASCULAR:

Chest Pain    High blood pressure    Low blood pressure    Irregular heart-rate    Pacemaker  
Anemia    Bypass    Heart problems    Circulation/Vascular problems    Blood Disorders  
Blood Clots    Blood Thinners    Leg cramps-at night    Leg cramps-walking

## LUNG:

Lung problems    Shortness of breath    Asthma    Emphysema    COPD    Tuberculosis

## NEUROLOGICAL:

Seizures/Epilepsy    Stroke/CVA/TIA    Headaches    Head Injury    Multiple Sclerosis  
Parkinson's disease    Muscular Dystrophy    Vertigo/Balance disorders    Dizziness  
Numbness    Coordination problems    Difficulty walking    Weakness/paralysis

## EARS/EYES:

Cataract    Cataract Surgery    Poor vision    Current use of glasses    Legally blind  
Hearing loss    Deafness    Hearing Aid    Ear Infections    Ear Ringing/Buzzing

## PSYCHOLOGICAL:

Depression    Mental Disorder    Nervous Breakdown

## GENERAL/METABOLIC:

Diabetes/High blood sugar    Low blood sugar    Allergies    Cancer (type) \_\_\_\_\_  
Kidney problems    Thyroid problem    Ulcers/Stomach problems    Bowel/Bladder problems  
Skin disease/condition    Repeated infections    Hepatitis    HIV/AIDS    Pain at night  
Unexplained weight loss/gain    Fever/chills    Nausea/vomiting    Fatigue/tiredness/malaise  
Difficulty sleeping

## SURGERIES:

Spine    Extremity    Brain    Thyroid    Heart    Bowel    Kidney    Gall bladder  
Appendectomy    Prostate    Hernia    Hysterectomy    Stent    Other: \_\_\_\_\_

## QUESTIONS:

Do you smoke?	YES	NO	Do you drink?	YES	NO
Are you pregnant?	YES	NO	Are you overweight?	Yes	NO

# **DYNAMIC PHYSICAL THERAPY & AQUATIC REHABILITATION CENTERS, INC.**

## **RELEASE OF MEDICAL INFORMATION & FINANCIAL RESPONSIBILITY:**

I, \_\_\_\_\_ HEREBY AUTHORIZE THE RELEASE OF MY  
(PLEASE PRINT NAME)

MEDICAL INFORMATION TO DYNAMIC PHYSICAL THERAPY & AQUATIC REHABILITATION CENTERS, INC., INCLUDING THE REVIEWING AND COPYING OF ALL HOSPITAL, MEDICAL AND REHABILITATION RECORDS AS WELL AS DISCUSSING WITH MY PHYSICIAN, NURSE, VOCATIONAL REHABILITATION, PHYSICAL OR MENTAL HEALTH CARE PROVIDERS MY MEDICAL DIAGNOSIS, TREATMENT CARE AND PROGNOSIS.

I, ALSO AUTHORIZE DYNAMIC PHYSICAL THERAPY & AQUATIC REHABILITATION CENTERS TO RELEASE MEDICAL INFORMATION CONCERNING ME TO: \_\_\_\_\_  
FOR THE PURPOSE OF: \_\_\_\_\_

A PHOTOCOPY OF THIS RELEASE AS SIGNED BY ME MAY BE USED IN LIEU OF AN ORIGINAL AND ANY SUCH PHOTOCOPY SHALL HAVE THE SAME VALIDITY AS IF IT WERE AN ORIGINAL.

THIS RELEASE SHALL REMAIN IN EFFECT FOR ONE (1) YEAR FROM THE DATE INDICATED BELOW.

I UNDERSTAND THAT I WILL BE PROVIDED WITH A COPY OF THIS RELEASE UPON REQUEST.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO DYNAMIC PHYSICAL THERAPY & AQUATIC REHABILITATION CENTERS, INC., FOR PROFESSIONAL SERVICES RENDERED.**

**I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.**

**I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL OUTSTANDING BALANCES FOR TREATMENT RENDERED AT DYNAMIC PHYSICAL THERAPY & AQUATIC REHABILITATION CENTERS, INC.**

**I AGREE TO SURRENDER ANY AND ALL PAYMENTS MADE TO ME PERSONALLY BY THE INSURANCE CARRIER FOR SERVICES PROVIDED TO DYNAMIC PHYSICAL THERAPY & AQUATIC REHABILITATION CENTERS, INC.**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

# **DYNAMIC PHYSICAL THERAPY & AQUATIC REHABILITATION CENTERS, INC.**

## **PATIENT INFORMATION SHEET:**

THE MISSION OF DYNAMIC PHYSICAL THERAPY & AQUATIC REHABILITATION CENTERS, INC., IS TO PROVIDE QUALITY EVALUATIONS, TREATMENT AND EDUCATION TO PEOPLE WITH PHYSICAL DISABILITIES, ILLNESSES OR INJURIES AND TO PROMOTE WELLNESS.

DURING YOUR THERAPY SESSIONS, WE WILL WORK WITH YOU TO HELP YOU ACHIEVE YOUR TREATMENT GOALS.

IN ORDER TO MAXIMIZE THE BENEFITS OF PHYSICAL THERAPY, WE SUGGEST THE FOLLOWING:

\*ASK QUESTIONS REGARDING YOUR CONDITIONS, TREATMENT AND RESPONSE TO TREATMENT, LENGTH OF TREATMENT AND THERAPY CHARGES.

\*YOU AND YOUR THERAPIST ARE PARTNERS. THE THERAPIST WILL EDUCATE YOU AND OFTEN GIVE YOU EXERCISES TO DO AT HOME. YOUR COMPLIANCE WITH THE THERAPIST'S RECOMMENDATIONS WILL HELP YOU REACH YOUR GOALS.

\*PLEASE LET YOUR THERAPIST KNOW WHEN YOUR NEXT VISIT TO YOUR PHYSICIAN IS SCHEDULED SO A PROGRESS REPORT CAN BE SENT.

\*IF YOU MUST CANCEL AN APPOINTMENT, PLEASE CALL OUR OFFICE AS SOON AS POSSIBLE. SOME INSURANCE COMPANIES REQUIRE THAT WE DOCUMENT THE REASON FOR THE CANCELLATION.

THANK YOU FOR CHOOSING DYNAMIC PHYSICAL THERAPY & AQUATIC REHABILITATION CENTERS, INC. WE LOOK FORWARD TO WORKING WITH YOU.

IF YOU SHOULD HAVE ANY CONCERNS OR SUGGESTIONS, PLEASE LET OUR STAFF KNOW.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS:

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

# DYNAMIC PHYSICAL THERAPY & AQUATIC REHABILITATION CENTERS, INC.

## TRANSPORTATION FOR REHABILITATION PATIENTS:

TRANSPORTATION IS A SERVICE PROVIDED BY DYNAMIC PHYSICAL THERAPY & AQUATIC REHABILITATION CENTERS, INC. AT **NO ADDITIONAL COST**. WHEN USING THE TRANSPORTATION SERVICE, PLEASE REMEMBER THE FOLLOWING:

1. PLEASE SCHEDULE FOR YOUR RIDE EACH WEEK IN ADVANCE.
2. YOUR SCHEDULED TIME IS THE TIME YOU WILL BE PICKED UP, NOT YOUR THERAPY TIME.
3. PLEASE ALLOW A 10-15 MINUTE WINDOW PRIOR TO AND FOLLOWING SCHEDULED TIME FOR UNEXPECTED TRAFFIC EVENTS.
4. CANCELLATIONS SHOULD BE MADE 24 HOURS IN ADVANCE.
5. ALL PASSENGERS ARE REQUIRED TO WEAR SEATBELTS.
6. SMOKING IS STRICTLY PROHIBITED IN ALL OF OUR VEHICLES.
7. PLEASE BE CONSIDERATE OF THE DRIVERS AND OTHER PASSENGERS.

PATIENTS WHO ABUSE THIS **FREE** SERVICE WILL BE ASKED TO FIND THEIR OWN FORM OF TRANSPORTATION.

PLEASE LET US KNOW IF THERE IS ANYTHING ELSE WE CAN DO TO AID YOU IN A HEALTHY RECOVERY.

THANK YOU FOR ALLOWING US TO SERVE YOU.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS:

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

# DYNAMIC PHYSICAL THERAPY & AQUATIC REHABILITATION CENTERS, INC.

## PATIENT CONSENT FORM:

I UNDERSTAND THAT UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:

1. CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE.
2. OBTAIN PAYMENT FROM THIRD-PARTY PAYERS.
3. CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN CERTIFICATIONS.

I HAVE BEEN INFORMED BY YOU OF YOUR *NOTICE OF PRIVACY PRACTICES* CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATION. I HAVE BEEN GIVEN THE RIGHT TO REVIEW SUCH *NOTICE OF PRIVACY PRACTICES* PRIOR TO SIGNING THIS CONSENT. I UNDERSTAND THAT THIS ORGANIZATION HAS THE RIGHT TO CHANGE ITS *NOTICE OF PRIVACY PRACTICES* FROM TIME TO TIME AND THAT I MAY CONTACT THIS ORGANIZATION AT ANY TIME AT THE ADDRESS BELOW TO OBTAIN A CURRENT COPY OF THE *NOTICE OF PRIVACY PRACTICES*.

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS BUT IF YOU DO AGREE THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT YOU HAVE TAKEN ACTION RELYING ON THIS CONSENT.

PATIENT NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

DATE: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_