Medical History Form

Welcome to Sawtooth Physical Therapy. Please take a moment to fill out your medical history as accurately and completely as possible. This information helps us to deliver the most comprehensive care to you. Your physical therapist will review this information with you during your first appointment.

Name: _____ Date of Birth: _____

CURRENT INJURY CONDITION:

Why are you coming here today (describe injury or condition)? _____

_____

When did your condition Begin? _____ Work Related: ☐ Yes ☐ No Next MD appointment *(date):* _____

Surgery Date *(if applicable)*: _____ Type of Surgery: _____

CURRENT SYMPTOMS:

Rate symptom intensity in the past 5 days (0 is no pain or symptoms, 10 is the worst imaginable pain or symptoms):

Symptoms at worst: _____ Symptoms at Best: _____

Have you received other therapies in the past 12 months? ☐ Yes ☐ No

MEDICAL CONDITIONS: (Do you have a history of?)

Yes	*No*		*Yes*	*No*		*Yes*	*No*	
☐	☐	Abnormal Bleeding	☐	☐	Degenerative Joint	☐	☐	Joint Pain
☐	☐	Angina	☐	☐	Depression	☐	☐	Lymphedema
☐	☐	Anxiety	☐	☐	Diabetes (Type 1)	☐	☐	Migraine Headaches
☐	☐	Arrhythmia	☐	☐	Diabetes (Type 2)	☐	☐	MRSA
☐	☐	Asthma	☐	☐	DVT	☐	☐	Multiple Sclerosis
☐	☐	Bipolar Disorder	☐	☐	Fibromyalgia	☐	☐	MI/Heart Attack
☐	☐	Blood Clotting Disorder	☐	☐	Frequent UTI	☐	☐	Osteoarthritis
☐	☐	Bowel Incontinence	☐	☐	GERD	☐	☐	Osteoporosis
☐	☐	Cancer	☐	☐	Glaucoma	☐	☐	Psoriatic Arthritis
☐	☐	Carpal Tunnel Syndrome	☐	☐	Gout	☐	☐	PVD
☐	☐	Cellulitis	☐	☐	Heart Disease	☐	☐	Rheumatoid Arthritis
☐	☐	Chronic Back Pain	☐	☐	Hep B	☐	☐	Scoliosis
☐	☐	Chronic Neck Pain	☐	☐	Hep C	☐	☐	Seizure Disorder
☐	☐	Crohn's Disease	☐	☐	Hiatal Hernia	☐	☐	Shortness of Breath
☐	☐	Closed Head Injury	☐	☐	High Cholesterol	☐	☐	Sleeping Disorder
☐	☐	Colitis	☐	☐	HIV/AIDS	☐	☐	TB
☐	☐	Congestive Heart Failure	☐	☐	Hypertension	☐	☐	Urinary Incontinence
☐	☐	COPD	☐	☐	Hypothyroidism	☐	☐	Other: _____
☐	☐	CVA (Stroke)	☐	☐	Irritable Bowel Syndrome	☐	☐	Other: _____

Do you have a pacemaker? ☐ Yes ☐ No Are you currently pregnant? ☐ Yes ☐ No

MEDICATIONS:

Please list all prescription and over-the-counter: *(attach separate sheet if necessary):* _____

_____

_____

VITAMINS & SUPPLEMENTS:

Please list all vitamins & supplements: _____

_____

ALLERGIES:

Please list any known allergies: _____

SURGICAL HISTORY:

Please list all past surgeries with dates: _____

_____

DIAGNOSTIC TESTS:

Have you had any X-rays? MRI? CT Scan? Ultrasound? Other? related to this condition *(Please List):*

_____

_____

SOCIAL HISTORY:

Do you currently smoke? ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never Packs/Day: _____

Have you smoked in the past? ☐ Yes ☐ No How many years did you smoke for? _____ Packs/Day: _____

How many years ago did you quit smoking? _____

Do you drink alcohol? ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never Drinks/week: _____

Hobbies / Activities? _____

FUNCTIONAL STATUS:

Occupation: _____ Work Status: _____ Restrictions: _____

Normal Work Duties:	Yes	No (*able to perform)*		Yes	No
Sitting for extended periods of time	☐	☐	Lifting Heavy Weights	☐	☐
Standing for extended periods of time	☐	☐	Operating Heavy Equipment	☐	☐
Repetitive Bending	☐	☐	Driving	☐	☐
Repetitive Lifting	☐	☐	Typing / Computer Operation	☐	☐
Lifting moderate Weights	☐	☐	Walking	☐	☐

Have you fallen in the last 12 months? ☐ Yes ☐ No How Many falls? _____

If patient is a minor: Mother's Name: _____ Phone: _____

Father's Name: _____ Phone: _____

Patient (Guardian) Signature: _____ Date: _____

Consent - Payment Authorization

SAWTOOTH
Physical Therapy

PLEASE READ AND SIGN THE FOLLOWING:

CONSENT TO TREATMENT:

I, the undersigned, do hereby agree and give my consent for Sawtooth Physical Therapy to furnish medical care and treatment as considered necessary and proper in diagnosing and treatment for my physical condition. I agree to promptly inform Sawtooth Physical Therapy of any changes to my medical history.

MEDICAL INFORMATION MAY BE RELEASED TO: Spouse: _____

Parent: _____ Other: _____

Would you like us to correspond with your primary care physician regarding your care? ☐ Yes ☐ No

Who is your PCP?: _____

PAYMENT AUTHORIZATION:

I authorize the payment of insurance benefits to Sawtooth Physical Therapy. I authorize the release of any information to and from any medical facilities, physicians, my insurance company, and to any person listed above in the medical information release section. I further agree that a photocopy of this agreement shall be as valid as the original.

My signature below acknowledges that I have been offered a copy of the Notice of Privacy Practices for Sawtooth Physical Therapy and have been given a copy if requested.

I agree to notify the office of any changes to my address, phone number, employment, and insurance.

I understand that as a courtesy to all patients in the clinic, if I am more than 10 minutes late for an appointment it may be rescheduled and if a cancellation is not made at least 24 hours prior to a scheduled appointment, a $25 dollar charge will be submitted to my account.

Furthermore, I understand that I will be charged $50 for not showing to an appointment and I understand that multiple no-shows or rescheduled appointments may be grounds for dismissal.

I acknowledge and understand that electronic communication may be used as a form of communication to and from patients of Sawtooth Physical Therapy. I understand that I have the right to communicate electronically with Sawtooth Physical Therapy staff and therapists.

I HAVE READ THE ABOVE INFORMATION ON THIS SHEET AND HAVE AGREED:

Patient or Guardian Signature: _____ Date: _____

Financial Policy

Thank you for choosing Sawtooth Physical Therapy for your physical therapy needs. The following is our Financial Policy. If you have any questions or concerns about our payment policies, please do not hesitate to contact our billing office.

We ask that all patients read and sign the Financial Policy. All patients must have one form of picture identification such as a valid driver's license.

Insured Patients: Sawtooth Physical Therapy will bill your insurance company solely as a courtesy to you. I understand that I am responsible for the entire account, less any insurance contractual agreements, when services are rendered. Sawtooth requires that payment of your estimated share, including contractual co-pays, be made at the time of service. In the event your insurance company requests a refund of payments made, you will be responsible for the amount refunded to your insurance company.

I hereby authorize my health insurance company to make payment directly to Sawtooth Physical Therapy for any benefits I may receive. I realize that this may not represent the full payment for services rendered and that I will be held responsible for the balance due within 90 days.

I authorize release of any information necessary to process my insurance claims and facilitate payment of my account by a third party.

Cash Patients: Full Payment for services is due at the time services are rendered.

Workers Compensation: If you are requesting we bill "Workers Compensation" for an established claim, please be advised that should your claim be denied, you will be responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be held responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees. Additionally, I understand that if I pay with a check, and it is subsequently dishonored, I will be responsible for the payment plus any bank processing fees incurred by Sawtooth Physical Therapy.

Patient or Guardian Signature: _____ Date: _____