ADVANCED PHYSICAL THERAPY, LLC

4000 Old Court Rd., Suite #100

Pikesville MD 21208

Tel: (410)-415-0005

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Health Questionnaire

Patient Name: _____ Date: _____

Patient Address: _____

_____

Describe the problem that brings you to physical therapy:

_____

_____

_____

Date problem began: _____

Have you had treatment for this problem? If so, please describe:

_____

_____

_____

Was this a result of an accident: Yes □ No □

If yes, check one of the following: □Automobile □ Pedestrian □Work-related □Other ___

Do you have pain: Yes □ No □

Please rate your pain on the following scale:

(Less Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe Pain)

Is pain **constant** or **does it come and go**? (Circle one).

What activities INCREASE pain/ symptoms? _____

What activities DECREASE pain/ symptoms? _____

What is your occupation? _____

What activities does your work require? (Lifting, sitting, standing, etc.) _____

Are you currently working? Yes □ No □

Health History

Check any conditions or diseases you currently have or had in the past:

____ Breathing Problems ____ Heart Attack ____ Arthritis

____Metal Implants ____ Visual Impairment ____ Seizures

____ Previous Surgeries ____ Fractures ____ High Blood Pressure

____ Hearing Aid ____ Pacemaker ____ Joint Replacements

____ Currently Pregnant ____Open Wounds ____ Alcohol/Drug Abuse

____ Cancer ____ Skin Condition ____ Infectious Disease

____ Light-headed/Fainting ____Ankle swelling, varicose veins or blood clots in the legs

____ Other (please specify) _____

Please explain and provide dates for all items checked above:

_____

_____

_____

List any prescribed medications you are now taking.

_____

_____

_____

List any over-the-counter medications or dietary supplements you are now taking:

_____

_____

_____

Informed Consent Agreement

I, hereby agree and give my consent for Advanced Physical Therapy, LLC to provide me with medical care and treatment that is considered necessary and proper in diagnosing and/or treating my physical condition. I have been informed of, and given the right to review and secure a copy of Notice of Privacy Practices. The Notice of Privacy Practices contains a description of the uses and disclosures of my protected health information as well as my rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). By signing this form, I consent to the Advanced Physical Therapy's use and disclosure of my health information to my health/ automobile insurance carrier, primary care physician/ referring specialist and/or attorney's office for treatment, payment, and health care operations. I also authorize to release my protected health information to the following:

Name of Person/ Company: _____ Date: _____

I understand that I have the right to revoke this consent at any time in writing by sending the request to: 4000 Old Court Rd, Suite 100, Baltimore, MD 21208. If I do, my revocation will not have any effect on any actions Advanced Physical Therapy, LLC has already taken in reliance on this consent. I hereby assign all medical and physical therapy benefits to which I am entitled, including Medicare, private insurance, and third party payers to Advanced Physical Therapy, LLC. I also understand that I am ultimately responsible for all charges, including my co-pays and deductibles, if any. I authorize Advanced Physical Therapy, LLC to obtain copies of necessary records from any hospital, doctor, or other medical provider who has treated or examined me for any condition that pertains to and/or improves the Practice's ability to provide quality rehabilitation services. I authorize the use of this signature on all insurance submissions. This agreement will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as an original.

_____ _____

Signature of a Patient or Authorized Representative Date