CONFIDENTIAL CASE HISTORY

SEAN EARLY PHYSICAL THERAPY
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Office: 702-330-3073
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Date: ____________________________

Full Legal Name: ____ **Name you prefer:** _______________

Address: ____ **City/State/Zip**_________________

Phone: (home) _____________________ **(Cell)** ___________________ **Soc Sec#**______-_______-_______

Birth date: ______/_________/__________ **Age:** ___ **Sex:** ___ **Marital Status: S M W D Sep**

Spouse's Name:____________________ **# Children** ________ **Years of Education**______________

Your Employer: ________________________________**Job Title:** ______________________________________

Emergency Contact: ____________________________ **Phone:** _________________________________

E-mail address: ____

MEDICAL HISTORY *(please be complete)*

List any surgeries (include dates & reason):____

List any hospitalizations (include dates & reason):____

List any auto accident injuries (include dates):____

List any current or past major medical conditions you have had (cancer, diabetes, heart disease, arthritis, etc.):____

Have you been under a physician's care in the past year? No ☐Yes ☐(reason) ____________________

When was your last physical examination? _________________________ **Dr:** ____________________

If female, is there a possibility that you are pregnant? No ☐ Yes ☐

Check any of the following symptoms you have noticed:

- ☐ Headaches
- ☐ Dizziness or light-headed
- ☐ Jaw pain, clicking, or locking
- ☐ Pain or difficulty swallowing
- ☐ Neck pain or stiffness
- ☐ Shoulder pain
- ☐ Mid back pain
- ☐ Chest pain or cough
- ☐ Pain/trouble breathing
- ☐ Arm/hand numbness/tingling
- ☐ Arm/hand fatigue/weakness
- ☐ Low back pain
- ☐ Leg/foot numbness/tingling
- ☐ Leg/foot fatigue/weakness
- ☐ Leg pain with walking
- ☐ Abdominal pain
- ☐ Nausea or vomiting
- ☐ Diarrhea or constipation
- ☐ Blood in urine or stool
- ☐ Difficulty or pain w/ urination
- ☐ Difficulty with sexual function
- ☐ Abnormal menstrual periods
- ☐ Sensitive to light or sound
- ☐ Visual or hearing disturbance
- ☐ Memory loss/problems
- ☐ Irritability or depression
- ☐ Fatigue or loss of energy
- ☐ Fainting or convulsions
- ☐ Trouble with balance or coordination
- ☐ Sleep disturbances/problems
- ☐ Rashes (face, body, limbs)
- ☐ Joint pain or swelling
- ☐ Pain with exertion (activity, climbing stairs, etc.)

Your current condition/complaint

What is your primary complaint/problem? ____________________

List other symptoms: ____________________

When did your symptoms first begin (give date if possible)?____________________

How did your symptoms first begin? ____________________

Pain is: ☐Constant ☐Intermittent Is your condition getting worse?__________

List *all* Doctors/therapists/specialists seen for this problem & treatment given (use back of page if necessary):

1.____________________

2.____________________

3.____________________

Have you had: ☐X-Ray ☐MRI or CAT scan ☐EMG ☐Bone Scan ☐Blood Work

Does your condition interfere with: (yes/no) work____ sleep____ normal daily routine__________

Have you had symptoms like this before? No☐ Yes☐(describe) ____________________

Regarding your main complaint:

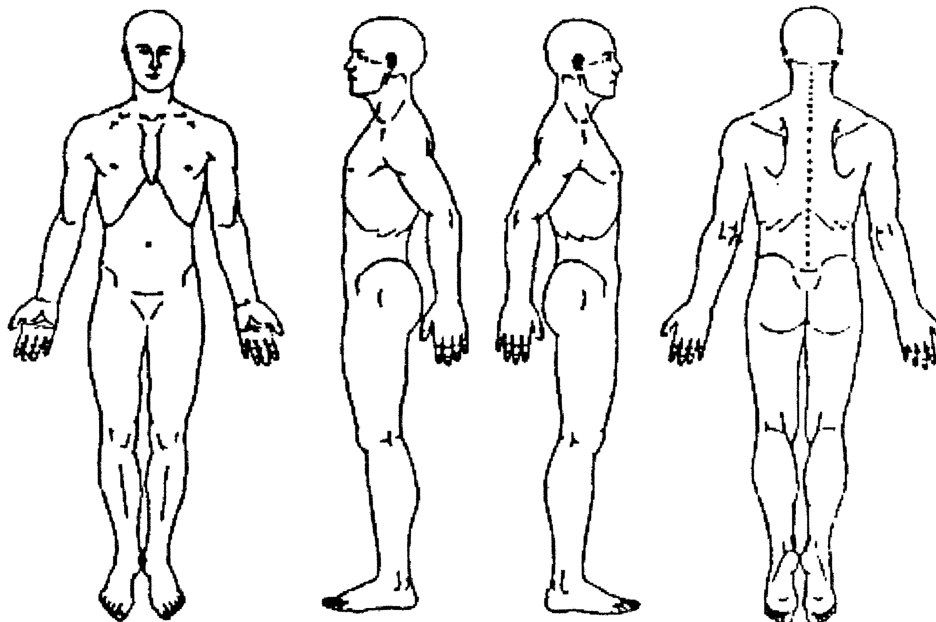
How bad is your pain?
(Make a slash on all 3 scales)

1. RIGHT NOW: 0____________________10
2. AVERAGE: 0____________________10
3. AT WORST: 0____________________10

0= no pain — 10=worst pain Imaginable

Draw the area of your symptoms using these symbols:
(mark on the figures)

A = Ache
N = Numb/Tingle
R = Radiating
S = Sharp/Stab
F = Stiff/Tight



<u>NOTICE TO NEW PATIENTS</u>: Payment in full for chiropractic services rendered is due in full at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the physician. We value and protect your privacy. I grant permission to the Dr. to use the information in my medical record to assist in the clinical improvement process.

Informed Consent to Treatment

I hereby request and consent to the performance of Physical Therapy, including various modes of manual therapy, therapeutic exercise, and modalities on me (or the patient named below, for whom I am legally responsible) by Sean Early Physical Therapy, and/or other licensed Physical Therapists or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for any of the PT's at Sean Early Physical Therapy.

I understand and I am informed that, in the practice of Physical Therapy there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the clinician to be able to anticipate and explain all risks and complications, and I wish to rely on the clinician to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts know, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

By signing this form, you are granting consent to Sean Early Physical Therapy to use and disclose your protected health information for the purposes of treatment, payment and health care operations.

<u>DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE</u>

____

Printed Name of Patient

______________________________________ ____________________

Signature of Patient **Date**

<u>CONSENT TO TREATMENT OF A MINOR</u>

____

Print Child's Name

______________________________________ ____________________

Parent or Guardian Signature **Date**

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Sean Early Physical Therapy as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

• The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for his/her treatment and care.
• We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated. Patients are responsible for knowing their copay and deductible information.
• Patients are responsible for the payment of co-pays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service.
• Patients may incur, and are responsible for the payment of additional charges at the discretion of Sean Early Physical Therapy. These charges may include (but are not limited to):

- o Charge for returned checks.
- o Charge for missed appointments without 24 hours advance notice
- o Charge for extensive forms completion.
- o Any costs associated with collection of patient balances including attorney/court costs. A past due account is any account that is not paid within 30 days of billing (statement) In the event that you fail to pay in full or make any kind of satisfactory payment arrangement (or we are unable to locate you/notify you of your account despite reasonable effort) your balance will be turned over to our outside collection agency. Any account turned over to collections will accrue a $ 50.00 collection charge, as well as interest of 1% per month.

Patient Authorizations

• By my signature below, I hereby authorize Sean Early Physical Therapy and the physicians, staff, and hospitals associated with Sean Early Physical Therapy to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payers, and/or other physicians or healthcare entities required to participate in my care.

• By my signature below, I hereby authorize assignment of financial benefits directly to Sean Early Physical Therapy and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

• By my signature below, I authorize Sean Early Physical Therapy personnel to communicate by mail, answering machine message, and/or email according to the information I have provided in my patient registration information. I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

_______________________________________ _______________________

Signature of Patient or Guardian Date Waiver of Patient Date