



Patient Intake Form

Patient Contact Information

First Name

Last Name

Date of Birth

Preferred Phone Number

Email

Home Address

Occupation/Sport

Employer/Level of Play (Pro, HS, Etc.)

Emergency Contact / Relationship

Emergency Contact Phone Number

Patient Questionnaire

How did you hear about us?

History of current condition

Any special tests that have been performed, the body part tested, and the results: (ie: X-Ray, MRI, Cat Scan)

Have you had any other treatments for your current condition? (ie: PT, Chiropractic, Massage, Acupuncture) Please list practitioners.

What activities or movements increase your pain or cause you to notice your symptoms more?

What activities or movements decrease your pain or cause a decrease in your symptoms?

What is your current exercise routine? What does a typical day look like for you?

Please list all previous injuries, accidents, and any other pertinent medical information.

Please list all medical conditions and/or health concerns.

Please list all current medications

Please list all allergies, including allergies to adhesives

Any previous surgeries? (please note year)

Do you now have or have you had any of these symptoms in the past year? (check all that apply)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Change in bowel movements | <input type="checkbox"/> Persistent joint pain | <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Blood in bowel/urine |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Vertigo or dizziness | <input type="checkbox"/> Persistent nose bleeds | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Learning disabilities | <input type="checkbox"/> Tiredness/fatigue | <input type="checkbox"/> Muscle spasms | <input type="checkbox"/> Fainting spells |

- Eating disorder/difficulty Difficulty sleeping Other

If "Other", please elaborate.

Any history of: (check all that apply)

- Head or spinal injuries Recurrent headaches Meningitis Stomach ulcers
- Heartburn/indigestion Shortness of breath Anemia Asthma
- Bladder infection Heart Problems Diabetes Depression
- Other

If "Other", please elaborate.

Informed Consent to Treat

Informed Consent

Permission for Treatment: You give permission to Athletic Potential Performance Physical Therapy, LLC staff (Dylan Newcomer PT, DPT, CSCS) to perform the necessary testing and treatment according to your diagnosis. You agree that no guarantee or promise has been made as to the results of services you are to receive nor that any treatment you receive will produce specific results. Charges/Guarantee of Payment: Athletic Potential Performance Physical Therapy, LLC charges \$150 for treatment sessions and \$240 for initial evaluations. You agree to pay the assigned charges at the time of scheduling the service.

Health Insurance: At this time, Athletic Potential Performance Physical Therapy, LLC does not bill insurance companies. You will be provided with receipts (a super bill) for all treatment received for you to submit to insurance companies if requested. Athletic Potential Performance Physical Therapy, LLC does not make any guarantees that your insurance provider will cover any services provided.

Permission for Release of Records and Medical Information: You give permission for Athletic Potential Performance Physical Therapy, LLC to give medical information and/or copies of any medical records to your physicians as needed to coordinate care. At times, records may be requested from your physicians in order to provide the most effective care, such as surgery notes or progress notes. Please note that this is an authorization for release of records that apply directly to your treatment. You may revoke this permission for any individual physician or all physicians at any time by providing written

revocation to Athletic Potential Performance Physical Therapy, LLC. Cancellation Policy: You agree to call, email, text or cancel in-person with Athletic Potential Performance Physical Therapy 24 hours before your visit when you are unable to complete your scheduled appointment time. You are aware that if you do not give 24 hour notice of cancellation, you will be subject to the cancellation fees detailed in the Financial Policy. Patient Rights and Responsibilities: You have received a copy of the patient privacy information form and understand it. Patient Conduct: You agree that Athletic Potential Performance Physical Therapy, LLC can stop providing care at any time for any reason. You agree and acknowledge that you may have additional people present at the time of the appointment. By requesting additional people be present at your appointment, you agree and acknowledge that you are authorizing the release of medical information to such individuals in the form of any discussions that take place during such appointment. Minors: Due to the nature of private therapy, Athletic Potential Performance Physical Therapy, LLC requires that a parent or legal guardian be present on the premises during appointments for minors. Acknowledgement of Receipt of Notice of Privacy Practices: I have been given a copy of the "Notice of Privacy Practices" that describes how my health information may be used and disclosed and how I can access to my health information. I understand that the notice may be changed at any time as permitted by applicable law. I may obtain a current copy of the notice by contacting Athletic Potential Performance Physical Therapy, LLC. My signature below indicates that I have been provided with a copy of the "Notice of Privacy Practices." You agree and acknowledge that a photocopy or PDF version of this signed agreement will be as valid as the original. You agree that should you have any disputes with Athletic Potential Performance Physical Therapy, LLC or Dylan Newcomer that the state law will govern such disputes and that such disputes must be held at a court located in the county where you receive treatment.

Signature

Today's Date

Electronic Signature (Please type your name below and click "Submit") (Parent or Legal Guardian Signature if for Minor)