GRANDVIEW
PRIMARY CARE
& PERFORMANCE MEDICINE INSTITUTE

Medical History Form
Physical Therapy

Patient Contact Information

Name: _____ Age: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ Cell Phone: _____

Email: _____

Employer: _____Occupation/Sport: _____

Medicare # (if applicable): _____

How did you hear about us? _____

Reason for being seen today: _____ Body Part: _____L/R

Physical Therapy in the last year? Yes No (Circle One)

Consent for Treatment

I give my consent for Kaitlin Hartley, PT, DPT to furnish physical therapy assessments and treatment to me considered necessary and proper in diagnosing and/or treating my physical condition.

Our Payment Policy

Kaitlin Hartley PT, DPT does not interact with insurance carriers, with the exception of Medicare, thus putting the responsibility of any reimbursement a client wants to receive on the client. Grandview Primary Care does not accept the responsibility for any incorrect information provided by your insurance carrier regarding insurance benefits. All payments to be made at the time of service.

Signature: _____ Date: _____

Patient Questionnaire

Primary Care Physician: _____

Date of Onset/Injury/Accident: _____

Describe how your injury or condition started:

_____

What makes your symptoms better? _____

What makes your symptoms worse? _____

Are your symptoms getting? Better Worse Same (Circle one)

Are you currently working? _____ Work Restrictions? _____

Have you had any tests for this condition? Please circle.

X-ray MRI Injections CT scan N/A

If yes, date: _____

Are you currently being treated by:

Another Therapist: Yes or No OR within last 12 months: Yes or No

Chiropractor/Osteopath: Yes or No OR within last 12 months: Yes or No

Home Health Agency: Yes or No OR within last 12 months: Yes or No

Please circle all of the following that apply to you:

Alcohol/drug dependence	Asthma	Diabetes	Currently pregnant
High Blood Pressure	Epilepsy	Stroke	Pacemaker
Dizziness/Fainting	Back Injury	Fracture	Tobacco use
Osteoporosis	Arthritis	Cancer	Other:_____
Cardiac condition	Depression	Hepatitis	Shortness of breath (SOB)

Current Medications:

_____

_____

Current Allergies: _____

The above information is true and accurate to the best of my knowledge. I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignment of benefits.

Patient Signature: _____ Date: _____

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Cancellation Policy

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable; however, advance notification allows us to fulfill other patient's scheduling needs and keeps the clinic operating at its most efficient level.

Please provide our office with ***24-hour notice*** to change or cancel an appointment. Patients who do not attend a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment will be responsible for a **$20.00 fee.** This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment. If your appointment falls on a Monday, we ask that you would please call the office on the Friday prior to your scheduled appointment as our office is closed on Saturday and Sunday.

We understand that delays can happen however we must try to keep the other patients and healthcare providers on time. If a patient is 15 minutes past their scheduled time, the appointment will be shortened and end on time.

Patient Signature: _____ Date: ____/_____/_____