Ortho Pro Physical Therapy

Last name: _____ First: _____ Middle Init.: _____ Sex: M / F

Birth Date: _____ Marital Status: _____ Occupation: _____

Home address: _____ City: _____ State: _____ Zip: _____

Home ph: ( )_____ Work ph.: ( )_____ Cell ph: ( )_____

Email: _____ Driver's Lic: _____ Soc Sec # : _____

Employer: _____ Address: _____

Nearest friend or relative: _____ City: _____ Ph: _____

How were you referred _____

Area of Pain: _____ Date of Injury/When Symptoms Began:_____

Patients Signature: _____ ***Date:*** _____

Medical Insurance Information ***Please allow us to make a copy of your card***

Primary cardholder name: _____ ***Date of Birth***: _____

Is your injury or problem due to a work injury or accident? Yes / No _____

FOR OFFICE USE ONLY:

Entered in WebPT ☐ Scanned Forms (Intake, ins, etc.) ☐ Forms in WebPT ☐

Social Media ☐ POC/TY to MD ☐ Patient Follow-ups ☐ Ins benefits Pt. ☐

Assigned Therapist: _____

Patient History Form

Name: _____ Sex: M / F Age: _____ Height: ____ft ____in Weight: _____

1. Are you currently working? ___Yes ___ No (last day worked: _____)
2. Please give your occupation and physical demands: _____

_____

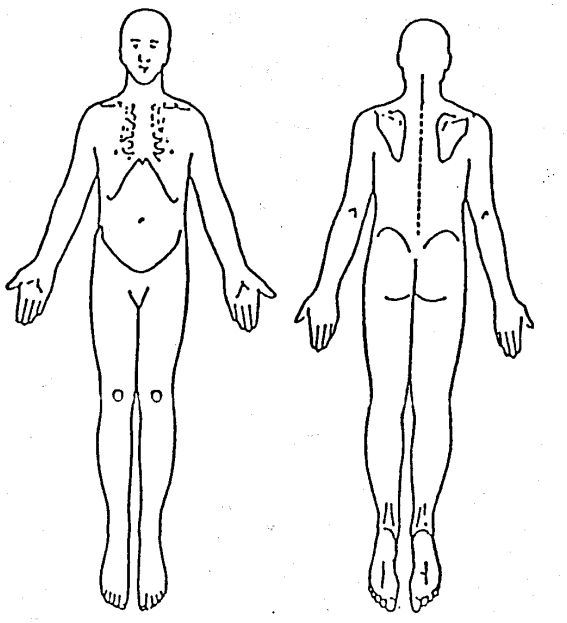
3. List your complaints or problems _____

_____

4. Please rate your level of pain between 1 – 10.

1 2 3 4 5 6 7 8 9 10
mild moderate extreme pain

5. Please indicate painful areas by shading the models to the right:



6. Which of the following describes your pain: (circle all that apply)

Sharp Dull Aching Tingling
Numb Constant Variable Radiating

7. How did your problem start?

_____

_____

8. Are there any positions or activities that make your pain worse? _____

_____

9. Are there any positions or activities that lessen your pain? _____

_____

10. Please list any medication(s) you are taking for this problem: _____

_____

11. What tests or treatment have you received for this problem? _____

_____

Past Medical History

12. Have you ever had any of the following?

Heart / Vascular Disease	***Yes/No***
Congestive Heart Failure	____
High Blood Pressure / Hypertension	____
Heart Attacks	____
Stroke / TIA	____
Pacemaker	____
Atherosclerotic Disease (CAD)	____
Angioplasty	____
Valve Disease	____
Arrythmia	____
Bypass Graft (CABG)	____
Atherosclerotic Disease (CAD)	____
Angioplasty	____
Valve Disease	____
Arrythmia	____
Angina	____

Lung Disease	***Yes/No***
Chronic Obstructive Disease (COPD)	____
Recent Pneumonia	____
Asthma	____
Acquired Respiratory Distress Syndrome	____
Emphysema	____

General Medical Conditions	***Yes/No***
Arthritis (rheumatoid/osteo)	____
Allergies	____
Neurological Conditions (MS, Parkinson's, etc)	____
Headaches	____
Gastrointestinal Disease (ulcers, hernia, IBS, Crohns, liver/gall bladder)	____
Visual Impairments	____
Back Pain (neck, back, disc disease, etc)	____
Hepatitis	____
HIV / AIDS	____
Osteoporosis	____
Depression	____
Kidney / Bladder / Prostate Issues	____
Incontinence	____
Hearing Impairments	____
Sleep Dysfunction	____
Prosthesis	____
Implants (metal, etc)	____
Cancer (active/remission)	____
Diabetes	____
Previous Surgeries (please write down)	____

13. Do you have metal anywhere in your body (other than teeth)? If so, where? _____

14. Are you pregnant? If yes, how many weeks/months? _____

15. List all allergies you have: _____

16. Have you ever had physical therapy treatments? If yes, when and for what? _____

_____

17. Have you had any physical/occupational/chiropractic/speech therapy this year? If yes, how many treatments? _____

(Other therapies this year may limit your allowed number of PT visits with us)

To the best of my knowledge, the stated medical information is true and correct.

Date:_____ Signature:_____

Ortho Pro Physical Therapy

AUTHORIZATION TO PAY PHYSICAL THERAPY PROVIDER / FINANCIAL AGREEMENT

I hereby authorize Ortho Pro PT / Jeff Waldberg, PT MOMT to charge my insurance company for services rendered including, but not limited to, manual therapy, modalities for pain management, and therapeutic exercise for flexibility and strengthening. I further authorize Ortho Pro PT / Jeff Waldberg, PT MOMT to furnish my insurance company my treatment records upon request.

I authorize and instruct _____ insurance company to pay for my services by payment going to:

Ortho Pro Physical Therapy or Jeff Waldberg, PT MOMT
1145 Lindero Canyon Rd. #D7
Westlake Village, CA. 91367

Please read the following and sign below.

1. This payment will not excuse my indebtedness to Ortho Pro PT / Jeff Waldberg PT MOMT

2. I understand that my insurance will on average be billed weekly. I agree that if my insurance does not pay within 60 days of being billed that it will then be my responsibility to make payment on any outstanding balance due.

3. I agree that any balance of said charges over and above those which have been paid by my insurance will be paid by me.

4. I agree that charges that are past due over 90 days will incur a finance charge of 5% of the unpaid balance. I understand and agree that balances past 120 days will be turned over to a collection, and any additional collection fees and finance charges will be paid by me.

5. I understand that there is a $25 fee for cancellations made on day of my set appointments. I also understand that there is a $25 fee for failure to show for any scheduled appointments. I acknowledge that this $25 fee, if accrued, is to be paid by me, separate from charges made by my insurance.

Date: _____ Patients Signature _____

Ortho Pro Physical Therapy

CONSENT TO TREAT

I, _____, hereby consent to routine Physical Therapy services as provided by Ortho Pro Physical Therapy & Jeff Waldberg, PT MOMT and his staff under his supervision. This will be done according to the general instructions of the referring physician (if applicable). I acknowledge that the treatment may include any number of modalities and/or procedures that will be rendered according to the general guidelines of my physician (if applicable) and the physical therapist.

Date: _____ Patients Signature: _____