Health History **The Performance Place**

To our patients: Please understand that in choosing The Performance Place for care you have chosen a facility where the goal is to return you to a level of function that hopefully leads to an increased level of activity and participation in a fitness program. Exercise will be tailored to the level of activity that you wish to return to. For those of you who wish to return to competitive activities or higher level performance we aim to return you to your prior training routine.

In order to help you to safely reach your goals we require that you check all items that apply as accurately as possible. Your answers are for our records and are considered confidential. Failure to disclose conditions that could adversely affect your safety during exercise could result in discharge from this facility. If you are under 18 a parent or guardian must cosign this form.

Patient Name____________________ Referred by____________________

Reason for today's office visit____________________

Is this visit related to an automobile, work related or other accident?__________ Date of Injury__________

Date of Surgery__________ Height__________ Weight__________ Age__________

Have there been changes in your general health in the past year?____________________

Have you passed out or lost consciousness while at rest or during exercise?____________________

Have you or do you currently have:

	Yes	No
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Con. Heart Failure	☐	☐
Damaged Heart Valves	☐	☐
Heart Murmur	☐	☐
Chest Pain/Angina	☐	☐
Heart Attack	☐	☐
Irregular Heart Beat	☐	☐
Cardiac Pacemaker	☐	☐
Heart Surgery	☐	☐
Stroke	☐	☐
TIA	☐	☐
Breathing Disorders	☐	☐
Blood Clots	☐	☐
Cancer	☐	☐
Convulsions/Epilepsy	☐	☐
Mental Health Problems	☐	☐
Rheumatoid Arthritis	☐	☐
Reynaud's Syndrome	☐	☐
Chronic Pain	☐	☐
Head Injury	☐	☐

Have you or do you currently have:

	Yes	No
Diabetes	☐	☐
Low Blood Sugar	☐	☐
Osteoporosis	☐	☐
Osteopenia	☐	☐
Bruise Easily	☐	☐
Anemia	☐	☐
Sickle Cell	☐	☐
Marfans	☐	☐
ADD/ADHD	☐	☐
Gout	☐	☐
Hernia	☐	☐
Hepatitis	☐	☐
Clotting Disorder	☐	☐
Chronic Fatigue	☐	☐
Contagious Disease	☐	☐
Delays in Healing	☐	☐
Neurologic Disorder	☐	☐
Dizziness	☐	☐
Lyme Disease	☐	☐
Pregnant	☐	☐
Numbness/Tingling	☐	☐

Please list any allergies, especially to latex, betadine, aspirin: ____________________

Alcohol Usage (Drinks/Day)__________ Do you smoke?__________ Packs/day__________

Please list current medications, past surgeries or any treatment that you are **currently** receiving related to your condition:____________________

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____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my therapist, athletic trainer, or any member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Consent for Care and Treatment: I agree to and give my consent for The Performance Place Physical Therapy and Sports Medicine to provide medical care and treatment for my diagnosis, as necessary. I understand that all fees and charges as a result of my visit are payable at the time the professional services are rendered. I authorize my insurance carrier, if applicable, to pay for these services for me. I agree to pay for charges not covered by insurance when they are billed to me.

Patient Signature:____________________ **Date:**__________

THE PERFORMANCE PLACE
PHYSICAL THERAPY AND SPORTS MEDICINE
REGISTRATION FORM
(Please Print)

PATIENT INFORMATION					
Today's date: / /	Patient Status: ❑ Initial Visit ❑ Returning, year of last visit: ______				
❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. Last: First: MI:			Marital Status : ❑ Single / ❑ Married / ❑ Other		
Employed: ❑ Full-time ❑ Part-time Student: ❑ Full-time ❑ Part-time Retired: ❑ Yes ❑ No	Birth Date: / /		Age:	Sex: ❑ M ❑ F	
Email:		Social Security No.: - -			
Local address: City/State/Zip :			Home Phone No.: ( )		
Permanent address (if different): City/State/Zip :			Cell Phone No.: ( )		
Occupation:	Employer:		Employer Phone No.: ( )		
Emergency Contact :	Relationship to Patient:		Phone No.:		
Patient's Relationship to Subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other ______	
Insurance I.D. No. (if card not present) :			Group No.:		
Subscriber's Name (if different):					
Subscriber 's Birth Date: / /			Subscriber 's Sex: ❑ M ❑ F		
Referred to Clinic by : ❑ Dr. ______ ❑ Family ❑ Friend ❑ Close to Home / Work ❑ Website/Facebook ❑ Other ______					

BILLING INFORMATION	
Responsible Party:	Birth Date: / /
Address (if different) : City/State/Zip :	Home Phone No.: ( )

STUDENTS

As a courtesy, we can bill your parents for your co-payment, deductible and/or allowed coinsurance.

I acknowledge that I am personally responsible for any unpaid balance specified by my insurance, including co-payments, co-insurances or deductibles; or if I have no insurance, the Clinic's fees.

_______________________________ _______________

Patient/Guardian signature *Date*

SCHEDULING POLICY

Cancelled appointments, without 24 hours prior notification, will be charged a fee of $25.00. Missed appointments i.e. "no-shows" will be charged a fee of $50.00. These charges must be paid prior to continuation of therapy services. Two "no-shows" may result in discharge from Physical Therapy.

I acknowledge that I have read the scheduling policy and agree to the stated terms.

_______________________________ _______________

Patient/Guardian signature *Date*

FEES AND PAYMENTS

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physical therapist and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay copays, any deductible amount, coinsurance or any balance not paid for by your insurance company. You will be responsible for all collection costs, attorney's fees, and court costs.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to The Performance Place Physical Therapy and Sports Medicine, benefits that would otherwise payable to me.

I hereby acknowledge that a copy of this office's Notice of Privacy Practices and Patient Financial Responsibility Policy have been made available to me. I have been given an opportunity to ask any questions I may have regarding this Notice and Policy. I certify that the above information has been read and understood.

_______________________________ _______________

Patient/Guardian signature *Date*