NEW PATIENT INFO
PHYSICAL THERAPY PRE-EXAM QUESTIONNAIRE

In order to evaluate your condition fully, please be as accurate as possible.

Patient Name _____

Phone: _____ **Email:** _____

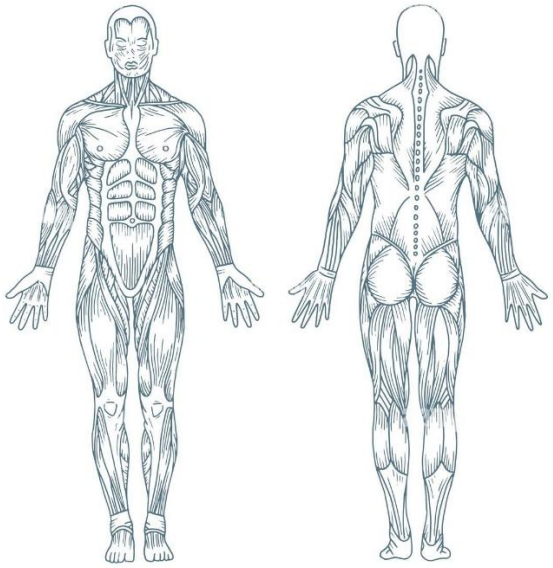
Address: _____ **City:** _____ **St:** ____ **Zip:** _____

Date of Birth _____ **S.S.N** _____

Gender (Circle) ☐ Male ☐ Female **Occupation** _____

Have You Had Physical Therapy Before (Circle) ☐ Yes ☐ No

Please Mark All Areas of Pain / Problem Areas on the Diagram Below:



Circle Your Pain Level:

1 … 2 … 3 … 4 … 5 … 6 … 7 … 8 … 9 … 10

Mild ☐ Moderate ☐ Severe ☐

Circle Your Pain Progression:

Getting Worse ☐ Getting Better ☐ Staying Same ☐

What Caused Your Pain / Problem Areas:

_____

_____

When Did These Problems Start / How Long Have You Experienced Pain:

_____

_____

Are You Taking Medication for this Pain / Problem? (Please List if So or Circle No)

☐ NO ☐ YES _____

Are Any Everyday Activities Affected by Your Pain / Injury (Please List if So or Circle No)

☐ NO ☐ YES _____

List All Past Surgeries and Dates:

_____
_____
_____
_____

List All Existing Medical Conditions:

_____
_____
_____
_____

ACKNOWLEDGEMENT & ACCEPTANCE OF PRIVACY NOTICE & PRACTICES (HIPAA)

I acknowledge I have been given an opportunity to read he offices Privacy Practices. I give my consent to release personal information for the purposes of treatment, referrals, and payment or healthcare operations and understand that I may withdraw this consent at any time in writing.

I understand that my medical records may be transmitted electronically by fax and may be received in error by a third party. If this should occur, I absolve the office of all liability. I give my consent o fax my records for the purposes of treatment, payment, or healthcare operations and understand that I may withdraw this consent at any time in writing.

I also understand that I have the right to request restrictions as to how my health information may be used or disclosed. I understand that I have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Other person(s) permitted to receive my medical records other than listed in the above paragraph:

☐ No restrictions – may release information if requested to anyone

☐ Restrictions – list who we may release information to regarding your healthcare:

_____

_____

_____

I wish to be contacted in the following manner (Fill in all that applies):

Phone: _____

Email: _____

_____ _____

Patient / Guardian Name Phone Number

ACKNOWLEDGEMENT & ACCEPTANCE OF USE FOR MARKETING

I acknowledge my likeness may be used in photography and videography for illustrating patient care and training services on print, social media, web, email, and other digital platforms under Atlet Medical LLC marketing and advertisements.

I consent to have my likeness and patient care used in these forms of marketing and advertising media.

_____ _____

Patient Name Parent / Guardian Name (If Applicable)

_____ _____ _____

Patient or Guardian Signature Date Phone Number