(Please Print Clearly)

Patient's First Name: _____ Last Name: _____ Middle: _____

Mailing Address: _____ City: _____ St: _____ Zip: _____

Street Address: _____ City: _____ St: _____ Zip: _____

DOB: ____ / ____ / ____ Patient's SS#: _____ / _____ / _____ DL #: _____ Gender: ☐ Male ☐ Female

Hm. Ph#: (____) _____ Cell #: (____) _____ Email: _____
(Recipient of surveys, aptm confirmation, etc)

Patient's Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other Student: ☐ Full-time ☐ Part-time

Employment Status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Self-Employed ☐ Retired ☐ Disabled

Place of Employment: _____ Occupation: _____

Wk.#: (____)_____ Address: _____ City:_____ St:_____ Zip:_____

Spouse's Name: _____ Spouse's DOB: ____ / ____ / ____ Spouse's SS#: ____ / ____ / ____

Spouse's Place of Employment: _____ WK#: (____) _____

Responsible Party/Guardian: (If not the patient; or If patient is a minor (under the age of 18):

First Name: _____ Last Name: _____ Middle: _____

Mailing Address: _____ City: _____ St: _____ Zip: _____

Street Address: _____ City: _____ St: _____ Zip: _____

DOB: ____ / ____ / ____ SS#: _____ / _____ / _____ DL #: _____ Hm. Ph#: (____) _____

Cell #: (____) _____

Place of Employment_____ Wk.#: (____)_____

Address: _____ City: _____ St: _____ Zip: _____

Emergency Contact: _____#(____)_____ Relationship: _____

Are you currently a wellness member here at MTS-LGH Therapy Services LLC? ☐ **Yes** ☐ **No**

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:
I authorize the release of any and all medical information necessary to process my claim for services provided by MTS-LGH Therapy Services LLC, and request payment of benefits to MTS-LGH Therapy Services LLC.

I hereby consent to the release and disclosure of my personal health information to MTS-LGH Therapy Services LLC. This release authorization includes my personal health information consisting of MRI results, test results, etc. for the purpose of deciding plan of treatment. I understand that MTS-LGH Therapy Services LLC is permitted to send me unencrypted emails that pertains personal health information if advised by me and I am aware of the risk.

Patient's/Responsible Party's Signature: _____ Date: _____

MTS-LGH Therapy Services LLC
Patient Information Acknowledgement Form

I have read and fully understand MTS-LGH Therapy Services LLC's Notice of Information Practices. I understand that MTS-LGH Therapy Services LLC may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that MTS-LGH Therapy Services, LLC will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby authorize the use and disclosure of my personal health information for purposes as noted in MTS-LGH Therapy Services LLC Notice of Information practices. I understand that I retain the right to revoke this authorization by notifying the practice in writing at any time.

I would like a copy of my initial evaluation sent to my home address. ☐ Yes ☐ No

_____
Patient Name

Designated Individuals Authorization Form

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please list any preferred physician's involved in your care: (Example: General/Family Physician, Orthopedist, Neurologist, Cardiologist, etc).

Physician's Name: _____ Specialty: _____

Physician's Name: _____ Specialty: _____

Physician's Name: _____ Specialty: _____

Physician's Name: _____ Specialty: _____

No Show Policy

In order for MTS-LGH Therapy Services LLC to effectively give the best possible treatment and care for our patient, it is imperative that our patients attend their scheduled appointments as referred by their physicians. If you are unable to attend your scheduled appointment, as a courtesy to our office, we ask that you call prior to your appointment time to cancel that appointment. If you consistently miss your scheduled appointments, our office will refrain from scheduling your next appointment, discontinue your treatment and notify your physician of your inability to keep your scheduled appointments. As a result, you will be required to see you physician for a new referral before returning to us for treatment.

Patient's Signature: _____ Date: _____

Patient's Name: _____ DOB: ____/____/_____ Date completed:_____

Referring Physician:_____ Return Date to Physician:_____

Are you receiving home health? Yes No If yes, Agency Name: _____ PH#: _____

(PLEASE NOTE: If you are a Medicare patient and you are receiving home health, Medicare will not pay for you to have outpatient PT & home health at the same time, please let the receptionist know immediately if this applies to you)

What caused you to seek physical therapy/medical attention? _____

Your condition is related to: Employment Auto Accident Home Other

Date of condition/accident: ____/____/_____ State Accident Occurred: _____

What is your major complaint? Please be as detailed as possible _____

_____

Have you had this problem before? ___ Yes ___ No

If you have pain, what is your pain level?
(0= No Pain, 10 = Extreme Pain – Circle)

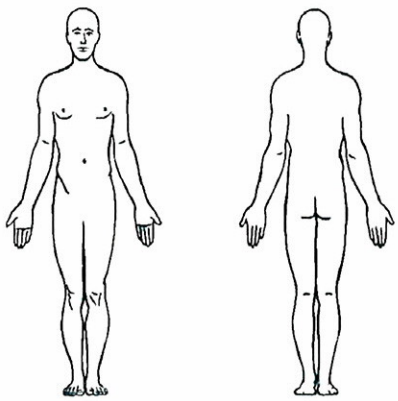
AT WORST: 0 1 2 3 4 5 6 7 8 9 10

AT BEST: 0 1 2 3 4 5 6 7 8 9 10

CURRENTLY: 0 1 2 3 4 5 6 7 8 9 10

Mark the location of your pain with an "X":

FRONT BACK



Are your symptoms: ____ Constant ____ Come & Go ____ Ache ____ Deep ____Superficial ____ Dull ____ Sharp

____ Shooting ____ Burning _____ Numbness/Tingling Other: _____

Does your pain seem to be WORSE at a certain time of day? _____ Yes _____ No

If Yes, _____ Morning _____ Night Other: _____

Does your pain progress as the day goes along? _____ Yes _____ No If Yes, please explain: _____

Do you have difficulty falling asleep? _____ Yes _____ No If Yes, please explain: _____

Do you wake due to pain? _____ Yes _____ No If Yes, # of times per night: _____

What were you doing prior to this injury that you are unable to do currently?

____ Squatting ____ Sitting ____ Driving ____ Reaching ____ Work Tasks ____ Holding/Carrying Objects

____ Lifting ____ Walking ____ Gripping/Pinching ____ Dressing/Grooming ____ Stairs ____ Position Change

____ Kneeling ____ Standing Other: _____

What household duties are you having difficulty performing? _____ Cooking _____ Cleaning _____ Vacuuming

_____ Laundry _____ Yard Work _____ Grocery Shopping Other: _____

Do you use an assistive device? _____ None _____ Cane _____ Walker _____ Wheelchair Other: _____

Did you use an assistive device prior to current injury/condition? _____ Yes _____ No

What activities make your pain better? _____

What activities make your pain worse? _____

Is this pain getting: _____ Better _____ Worse _____ Not Changing

What type of treatments have you received for this condition? _____ X-Rays _____Surgery

_____Chiropractic ___MRI _____ Medications _____Injection _____Bone Scan _____CT/CAT Scan

_____Physical Therapy _____Home Health Please describe (agency, etc.) _____

Have you fallen in the last 12 months? Yes No If yes, how many times? _____

Did your fall result in any injury? Yes No _____

PLEASE CHECK ALL PROBLEMS DIAGNOSED BY A DOCTOR. CIRCLE IF YOU ARE CURRENTLY BEING TREATED.

___Bronchitis/Emphysema/Lung Disease /COPD ___ Sciatica ___Osteoporosis/penia ___Heart Disease

___Pneumonia ___Fibromyalgia ___Implants ___ Lupus

___Abnormal Chest X-Ray ___Bursitis ___High/Low Blood Pressure ___Tuberculosis

___Chronic Fatigue Syndrome ___TMJ Dysfunction ___Dizziness/Fainting Spells ___Epilepsy

___Thrombosis/Phlebitis ___Muscular Dystrophy ___Pregnant – due _____ ___Diabetes

___ Rheumatoid Arthritis ___ Blood Thinner ___ Immunosuppression ___ Gout

___Carpal Tunnel Syndrome ___ Blood-Borne Pathologies: HIV AIDS Hepatitis A Hepatitis B Hepatitis C

___Tumors/ Cancer—Year_____ Type_____ Remission: Yes No

___Pace Maker—if Yes, date rec'd _____

___Sprains/ Dislocations/Broken Bones—Please List:_____

Please list all medications you are currently taking and what they are for [Specific name of medication, dosage, frequency & Route (Example: by mouth), please include over the counter, prescriptions, herbals & vitamins]:

_____

_____

Please list any previous surgeries: _____

_____

Height:_____ Weight:_____