



Patient Info + Health History

How did you hear about us? (Please Check) *

1) Doctor Referral: _____ 2) Family/Friends: _____ 3) Internet (Website/Social Media): _____
4) Print Media (Newspaper, Magazine, Value book): _____ 5) Email: _____ 6) Other: _____

Print Name: _____ Date of Birth: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Occupation: _____ Employer: _____ Work Phone: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Name: _____ Contact#: _____ Relationship: _____

Primary Insurance: _____ Secondary Insurance: _____

Why are you seeking care from a Physical Therapist? _____

When did your pain or symptoms start? _____

What kind of symptoms do you have? * **Sharp pain** _____ **Dull ache** _____ **Numbness/tingling** _____ **Other:** _____

What have you done for it so far? * _____ Pain scale: 1 2 3 4 5 6 7 8 9 10

Primary Position During the Day? * **Standing** _____ **Sitting** _____ **Moving** _____ **Other:** _____

Do you take any medications for current symptoms and/or other medical condition? * **Yes** _____ **No** _____

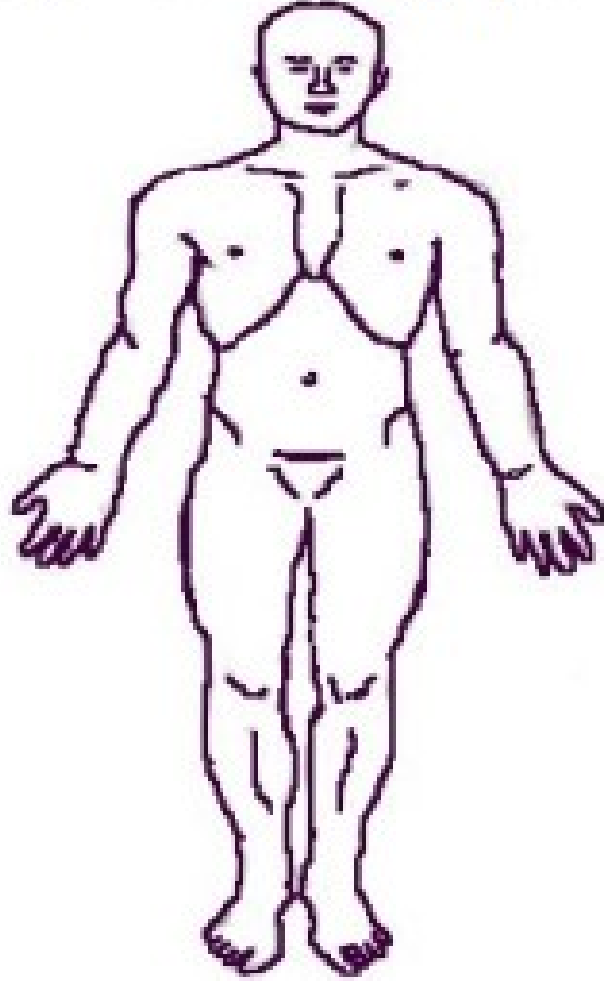
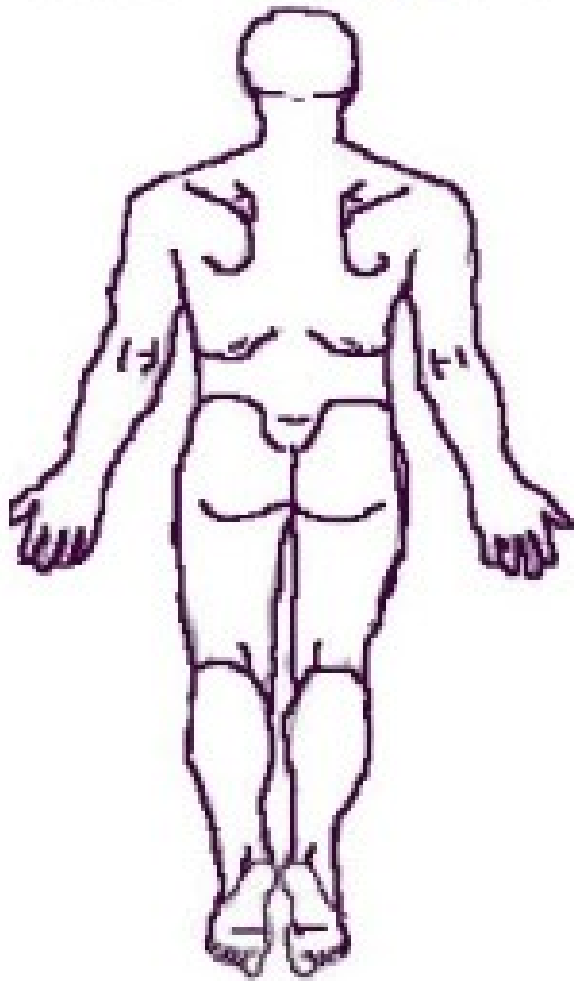
If yes, please list them: _____

Any major physical traumas in your life? Vehicle Accident _____ Recent Falls _____ Surgeries _____

If yes, please explain: _____



Indicate where you have pain or other symptoms:*



Results

Physical Therapy

CURRENT PAIN SYMPTOMS (Please check)*

LOCATION	LEFT	RIGHT	INTERMITTENT (I) OR CONSTANT (C) (Please Circle)	WHAT MAKES IT WORSE?	WHAT MAKES IT BETTER
Neck			I C		
Shoulder			I C		
Elbow			I C		
Wrist/Hand			I C		
Upper Back			I C		
Mid/Low Back			I C		
Pelvis			I C		
Hip			I C		
Knee			I C		
Ankle/foot			I C		
Others:			I C		

MEDICAL HISTORY *

	YES	NO		YES	NO
High Blood Pressure			Arthritis		
Cholesterol			Metal Implant(s)		
Dizziness			Stroke or TIA		
Headaches			Hernia		
Asthma			Cancer		
Cardiac Problems			Endometriosis		
Pacemaker			Depression		
Diabetes			Digestive Problems/Ulcers		
Circulatory Disorders			Other: _____ _____		





RESULTS REHABILITATION INC. (DBA Results Physical Therapy)
Cancellation Policy

The following is our policy regarding cancellations and “no shows.” We take this subject seriously because it can make the difference between whether you succeed in your treatment goals or not. Showing up for your scheduled sessions is one of your most important jobs.

We require a 24-hour notice in the event of a cancellation.

1. This notice can be telephonic at 619-437-6450 or through e-mail at results@resultsrehab.com
2. There is a **\$50.00** charge for a **cancellation without a 24-hour notice** or a “**No-Show.**” This charge cannot be billed to your insurance making it your direct responsibility to pay.
3. Your therapist(s) are contracted clinicians and do not get reimbursed for your sudden cancellation or “**No-Show.**” Please be courteous to all of those involved and cancel with greater than 24-hour notice so the appropriate schedule adjustments can be made and allow us to serve other patients in need of our services.
4. We reserve the right to discontinue your treatments after a series of missed or canceled appointments.

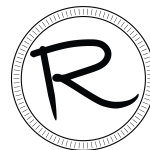
RESULTS REHABILITATION INC. (DBA Results Physical Therapy)
ACKNOWLEDGEMENT OF PATIENT INFORMATION PRACTICES

I understand that (Results PT) may disclose personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services or others listed on the notice. I understand that I have the right to restrict how my Protected Health Information (PHI) is used and disclosed for treatment, payment, and administrative operations if I notify the practice.

I hereby consent to the use and disclosure of my PHI as noted in the Results PT notice of patient information practices. I understand that I retain the right to revoke this consent by notifying Results PT in writing at any time. I have read and fully understand Results Rehabilitation Inc. (Results PT) notice of patient information practices.

Print Name : _____ Signature : _____

Date : _____





Informed Consent and Liability Waiver

I consent to the services provided at Results Rehabilitation Inc. These services include but are not limited to; rehabilitative procedures, manual joint mobilizations, massage, therapeutic exercises, and physical agents (ultrasound, low-level laser, electrical stimulation, traction, ice, heat therapy, etc.) to facilitate healing and aid the patient in recovery. I am voluntarily choosing to participate in and receive physical therapy. I will be expected to fully cooperate during the evaluation and treatment program in order to maximize results. I should not experience an increase in pain or discomfort beyond its current level during the evaluation and treatment program. If I feel increased pain, discomfort or feel apprehensive, it is my responsibility to ask the therapist to stop the procedure immediately. I will never be forced to perform any procedure that I do not wish to perform. There are certain inherent risks for physical therapy treatments because I will be asked to exert effort and perform activities with increased levels of difficulty. My therapist will take every precaution to ensure that I am protected from any potential hazardous situation. Based on the above information, I agree to cooperate fully, to participate in all physical therapy procedures, and comply with the plan of care as it is established.

I hereby give my consent to participate in physical therapy at Results Rehabilitation Inc. that includes my permission to be evaluated by a licensed physical therapist and receive treatment by licensed PT professionals. I, the undersigned, hereby release Results Rehabilitation Inc. and its employees, students, and volunteers from all liability arising out of or in connection with the above described activity or all liabilities associated with any and all claims related to such activity that may be filed on behalf of or for the below named patient. For purposes of this agreement, liability means all claims, demands, losses, causes of action, suits, or judgements of any and every kind that occurs during the above described activity and that results from any cause other than the negligence of Results Rehabilitation Inc.

Print Name: _____ Signature: _____

Date: _____

*If under 18 years of age:

Parent/Legal guardian Signature: _____

*** Upon request we are happy to provide you with a copy of the American Physical Therapy Association Guide of professional conduct.

