smartbody PHYSICAL THERAPY
Savor Life.

Welcome!

Thank you for choosing Smart Body Physical Therapy for your neuromuscular and/or musculoskeletal needs. We are committed to helping you achieve your rehabilitation goals in the most effective and efficient manner possible. In order to achieve these goals, we need your assistance.

Your Feedback: We believe it is essential you take an active role in your therapy, which includes giving us candid feedback on how effective your treatment is and how compliant you have been with your home exercises. If you have questions about your progress or have suggestions, please do not hesitate to discuss these concerns with your therapist.

Designated Treatment Area: In order to respect patient confidentiality, in addition to safety precautions, we request that visitors, spouses and other family members remain in the waiting area unless the patient's therapist requests their presence. Our patients deserve our undivided attention.

Adult Supervision: Minors (under the age of 18) receiving treatment at our facility must be accompanied by a parent or legal guardian during each physical therapy appointment.

Children: Please refrain from bringing children into the treatment area to ensure you have our full attention. Children under the age of 12 should not be left in the waiting area without adult supervision.

Appointments: We see patients by appointment only. Please call ahead if you think you will be late. We reserve the right to reschedule your appointment if you are more than 15 minutes late to your appointment.

Cancellations: A $50 fee will apply for each appointment that is canceled with less than 24 hours' notice. We require a card on file to process the payment at the time of the cancellation. You may leave a message on voicemail if you are calling after hours. If you miss two consecutive appointments without prior notification, your remaining appointments will be removed from our schedule. In order to return to therapy, you will need to call to reschedule your next appointment.

Courtesy: In consideration of our patients with breathing difficulties, please refrain from wearing heavy perfume/cologne.

Attire: For access to body parts being treated, loose fitting clothing is recommended. If your evaluation includes a diagnosis relating to the pelvis/pelvic floor muscles, you may need to undress and wear a gown, as an intra-vaginal or intra-rectal evaluation may be necessary as part of your evaluation. An example of this might be treatment for the diagnosis of urinary incontinence or leakage.

Authorization to Treat: I hereby consent and authorize the performance of all appropriate procedures and courses of treatment, which in the judgement of my provider may be considered necessary or advisable for my diagnosis/treatment. I have a condition requiring physical therapy care, and hereby consent to the rendering of such care, which may include such medical treatment as my attending physician(s) or other Smart Body Physical Therapy staff consider necessary. I understand that my medical care and treatment may be provided by a physical therapist, physical therapist assistant or physical therapist intern. It is understood that Smart Body Physical Therapy assumes no responsibility for personal property such as glasses, dentures, clothing, jewelry or other personal items.

Sincerely,
Laura Bunso, PT, MTC, President & Clinical Director

I HAVE READ, UNDERSTOOD AND AGREE TO THE ABOVE REQUESTS.

_____ _____
Signature of Patient or Guardian Date

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New Patient Paperwork

Patient Name: _____ Date of Birth: _____

Address:

_____

Street City State Zip

***Appointment Reminders will be sent via text, please provide a cell number below:

☐ Home Phone: _____ ☐ Cell Phone: _____ ☐ Work Phone: _____

Marital Status (Please Circle): Single Married Divorced Prefer not to disclose

Email Address: _____

☐ I would like to receive my home exercise program via email ☐ I would like to receive the Smart Body PT monthly newsletter

Emergency Contact:

_____

Name Relationship Number

Employment:

_____

(Patient)Job Title / Place of Employment

Who can we thank for referring you? (Please check all that apply) ☐ Friend/Family _____

☐ Physician: _____ ☐ ☐ Other _____

☐ Primary Care Physician: _____ Would you like us to include this physician in communication? ☐ Y ☐ N

☐ Google ☐ Print Advertisement ☐ Speaking Engagement ☐ Social Media

Insurance Information

Spouse's Name or Responsible Party: _____ Phone Number: _____

Primary Insurance Company: _____

Subscriber Date of Birth: _____ Subscriber SSN: _____ ☐ Self ☐ Spouse ☐ Parent

Please be advised, anyone who does not provide a secondary insurance company will be responsible for account balance.

Secondary Insurance Company: _____

Subscriber Date of Birth: _____ Subscriber SSN: _____ ☐ Self ☐ Spouse ☐ Parent

Please specify if you have been in a car accident or work-related injury that has brought you to our clinic.

☐ Auto Accident ☐ Work-Related Incident ☐ The reason I am here is not an auto or work-related accident:

_____ Date of Accident: _____ Claim/Case Number: _____

Adjuster Name: _____ Auto/Work Comp. Insurance Co.: _____

Phone Number: _____ Fax Number: _____ Claims Address: _____

Attorney Name (if applicable): _____ Attorney Number: _____

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Physical Therapy Goals

Patient Name: _____

What is the main reason you are at physical therapy?

_____

What are your goals for physical therapy?

_____

When did your problem begin? _____ Other treatments you have had for this issue? _____

What makes your symptoms better? _____What makes your symptoms worse? _____

Have you ever had physical therapy for this or another issue? If so, where, for what and for how long:

_____

What activities are you having difficulty with and want to improve? (Circle all that apply).

Walking	Bathing	Carrying	Movement	Getting on/off toilet	Getting in/out of car
Sitting	Eating Dressing	Meal Prep	Exercising	Going up/down stairs	
Reaching	Writing	Grooming	Standing	Sexual Function	Bladder/Bowel Control
Lifting	Work Duties	Home Activities	Self Care	Sports Activities	Getting in/out of bed

How much does this problem limit your overall function? 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Do you have any personal, cultural or spiritual needs we should know about in providing your therapy ☐ Yes ☐ No
If yes, please explain:

_____

Please include any additional information that would help us in providing your care (What you think would help, concerns, etc.):

_____

_____

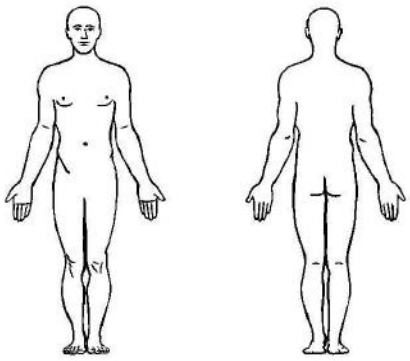
If you're not experiencing pain, please skip to page 3

Please rate your pain by circling below:
0 = No Pain, 10 = Worst Pain Imaginable

Please mark on the chart below to rate your pain level in the past week:

0 1 2 3 4 5 6 7 8 9 10

Worst Pain Level: _____/10, Lowest Pain Level: _____/10



Mark areas on the body where you are experiencing issues.

Please describe your pain (Circle all that apply):

Throbbing	Shooting	Stabbing	Sharp	Cramping
Aching	Heavy	Tender	Splitting	Sickening
Hot-Burning	Fearful	Cruel/Punishing	Gnawing	Tiring/Exhausting

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Medical History

Patient Name: _____I live ☐ Alone ☐ With a Significant Other ☐ With Caregiver

Primary Language ☐ English ☐ Spanish ☐ Other: _____

Next scheduled Dr. appointment: _____ Does your home have: ☐ Stairs ☐ Pets ☐ Rugs on Floor

Have you fallen in the past year? ☐ Yes ☐ No If so, how many times? _____ What injuries did you sustain? _____

Please list all medications, dosages and reasons for taking below (use another paper if necessary).

1) _____

2) _____

3) _____

Please list any surgeries and approximate year:

1) _____

2) _____

3) _____

Within the past year, have you had any of the following symptoms (Please circle)

Chest Pain	Heart Palpitations	Cough	Hearing Problems	Shortness of Breath	Vision Problems
Coordination Issues	Weakness	Balance Issues	Joint Pain/Swelling	Weight Loss/Gain	Walking Issues
Loss of Appetite	Bowel Problems	Urinary Problems	Difficulty Swallowing	Dizziness/ Blackouts	Headaches

Do you or your immediate family have a history of any of the following (Please check):

FAMILY	ME		FAMILY	ME	
☐	☐	Allergies	☐	☐	Lupus
☐	☐	Anxiety/Depression	☐	☐	Metal Implants
☐	☐	Asthma	☐	☐	Multiple Sclerosis
☐	☐	Abuse (emotional, physical or sexual)	☐	☐	Muscular Dystrophy
☐	☐	Blood Clots	☐	☐	Neurologic Disorder
☐	☐	Broken Bones	☐	☐	Osteoporosis
☐	☐	Cancer: _____	☐	☐	Osteopenia
☐	☐	Diabetes	☐	☐	Other: _____
☐	☐	Fibromyalgia	☐	☐	Pacemaker—Heart
☐	☐	Head Injury	☐	☐	Parkinson's Disease
☐	☐	Heart Disease	☐	☐	Pelvic Inflammatory Disease
☐	☐	High Blood Pressure	☐	☐	Peptic Ulcer Disease
☐	☐	Irritable Bowel Disease	☐	☐	Prostate Disease
☐	☐	Interstitial Cystitis	☐	☐	Psychiatric Disorders
☐	☐	Kidney Disease	☐	☐	Seizures/Epilepsy
☐	☐	Liver Disease	☐	☐	Skin Disease
☐	☐	Lung Problems	☐	☐	Stroke
☐	☐	Low Back Pain	☐	☐	Thyroid Disease

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Pelvic Health Medical History

Please disregard if you are not visiting us for a pelvic health related treatment.

Have you ever experienced or are you currently experiencing any of the following? (Please circle all that apply)

Bladder Disease or Infection	Frequent Diarrhea	Pain with Bowel Movements
Blood in Stool	Gastrointestinal Disease	Pain with Intercourse
Constipation	Laxative Usage (how much? _____)	Urine Leakage
Eating Disorder (what kind? _____)	Loss of Fecal Matter	Sexually Transmitted Disease

Women please continue on, men please skip to the next page and do not answer below questions. Please sign & date below, thank you!

When was your last:	Date:	Results:
1) PAP Smear	_____	_____
2) Mammogram	_____	_____
3) Bone Density DEXA Scan	_____	_____
4) Menstrual Period	_____	_____

Any changes in your period or cycle? _____

Any history of endometriosis? If yes, when was it diagnosed? _____

Do you wear a pessary or have an implant (ie. Interstim)? _____

Are you using hormones? If yes, what type? _____

If you have never been pregnant, please stop here. Please sign & date below, thank you!

1) Are you currently pregnant? ☐ Yes ☐ No If so, how many weeks: _____ 2) How many pregnancies? _____

3) How many deliveries? _____ 4) What type of delivery/deliveries? _____

5) Did you have an episiotomy? Tearing of rectum or vagina? ☐ Yes ☐ No _____

6) Have you ever had any significant low back or pelvic pain before or during pregnancy? ☐ Yes ☐ No _____

7) Did you have/are you having any complications during pregnancy? (ie. Bleeding, high blood pressure) ☐ Yes ☐ No _____

8) Any labor and delivery complications? (forceps, vacuum) ☐ Yes ☐ No _____

9) For your last delivery, how long was the labor? _____

10) For your last delivery, how long was the pushing phase? _____

11) What position were you in? (back, feet in stirrups, on side?) _____

12) Are you currently breastfeeding? ☐ Yes ☐ No

13) Are you here for a post-partum screening? ☐ Yes ☐ No

Patient Name: _____

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Records Release Authorization

I, _____, give permission to Smart Body Physical Therapy to release my medical records to the below mentioned:

Spouse or Family Member: (☐ Check if emergency contact from page 1 should be used)

Name: _____ Phone Number: _____

Mailing Address:

_____

Street City State Zip

Physician or other Health Care Providers:

Name: _____ Phone Number: _____ Fax Number: _____

Mailing Address:

_____

Street City State Zip

Name: _____ Phone Number: _____ Fax Number: _____
Mailing Address:

_____

Street City State Zip

Please Release the Following Information:

- ☐ Physical Therapy Evaluation & Plan of Care
- ☐ Daily Notes (From: _____ To: _____)
- ☐ Billing Records (From: _____ To: _____)
- ☐ Other Information:

_____

Patient Signature: _____ Date: _____

PRIVACY ACKNOWLEDGMENT:

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I hereby acknowledge that I have had the opportunity to review a copy of Smart Body Physical Therapy's (SBPT) "Notice of Privacy Practices". I understand that I am responsible to read this information and notify SBPT, in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. SBPT has the right to revise this Notice at any time and will post of copy of the current Notice in the office in a visible location at all times and on their website, smartbodypt.com. I am aware that SBPT has included a provision that it reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all protected health information it maintains. SBPT Will provide me with a copy of its most recent Notice upon my request.