

What specific results do you want from your therapy in your body and in your life? _____

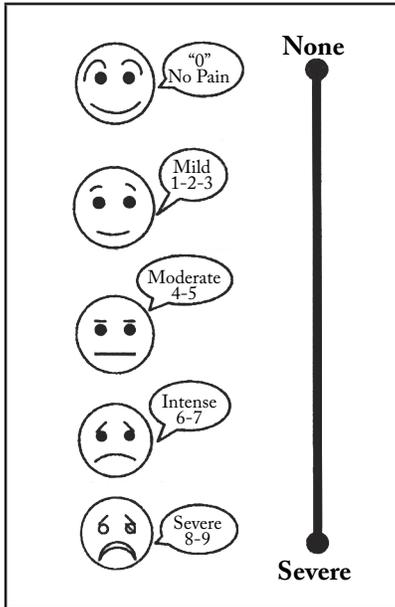
What are your functional goals (Be able to reach into lower cupboard without pain. Be able to drive longer. Be able to garden again. Be able to dress without pain)? _____

Please list any additional comments regarding your health and well-being: _____

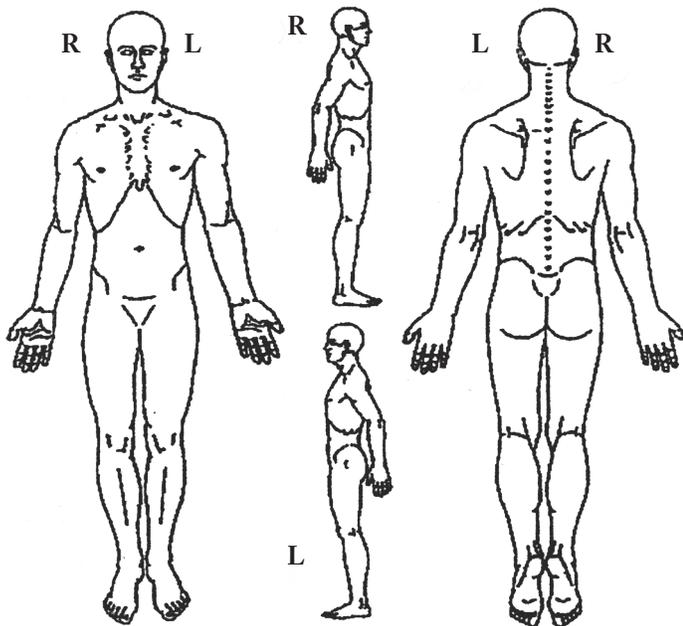
0-9 Pain Scale

Please use the following information when rating your pain.

Draw an 'X' on the vertical line to indicate the intensity of your pain.

	<p>Mild Pain: Pain does not interfere with most activities. You may use medication or devices such as cushions.</p> <ol style="list-style-type: none">1. Vague discomfort: very light, barely noticeable pain2. Minor pain3. Uncomfortable but tolerable <p>Moderate Pain: Pain interferes with many activities and requires lifestyle changes but you remain independent and functional.</p> <ol style="list-style-type: none">4. Annoying: medium, deep pain, like a toothache5. Very uncomfortable <p>Intense Pain: Pain interferes with your job or normal interactions. You require some assistance to function.</p> <ol style="list-style-type: none">6. Distressing or intense7. Very intense <p>Severe: You are unable to engage in normal activities. You find yourself disabled and unable to function independently.</p> <ol style="list-style-type: none">8. Excruciating9. Intolerable or unbearable: You consider going to the ER.
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Please indicate, on the figures below, the area(s) in which you are experiencing symptoms:



Please list your most painful areas and rate them using the 0-9 scale above

1. **Primary Area** _____

Usual pain level: _____

Lowest pain level in past week: _____

Highest pain level in past week: _____

% of time at highest pain level: _____

2. **Secondary Area** _____

Usual pain level: _____

Lowest pain level in past week: _____

Highest pain level in past week: _____

% of time at highest pain level: _____

3. _____

Usual pain level: _____

Lowest pain level in past week: _____

Highest pain level in past week: _____

% of time at highest pain level: _____

What % of time are you pain free? _____ %

HANDS-ON Physical Therapy Health History Questionnaire

Please indicate if you now have, or in the past had, any of the following (check all that apply).

Nervous System

- Head / Brain injury
- Stroke / TIAs
- MS / Parkinson's
- Peripheral neuropathy
- Epilepsy / Seizure disorder
- Other

Endocrine & Immune System

- AIDS / HIV positive
- Hepatitis A B C
- Diabetes type 1 or 2
- Thyroid imbalance
- Low blood sugar
- Cancer
- Other

Cardiac / Circulation System

- Heart attack
- Angina or chest pain
- Irregular heart rhythm
- Stents placed
- Bypass surgery
- Pacemaker or defibrillator
- Aneurism
- Blood clot
- Bleeding / Bruising tendency
- Deep vein thrombosis (DVT)
- High blood pressure
- High cholesterol

Respiratory System

- Asthma
- Emphysema or COPD
- Pneumonia
- Sinus surgeries / Deviated septum
- Allergies
- Other lung problem

Traumas

- Bad falls
- Dislocations
- Ligament tears
- Meniscus tears
- Motor vehicle accident
 1. When?
 2. When?
 3. When?

Musculoskeletal System

- Osteoarthritis
- Spinal stenosis
- Spondylolisthesis
- Herniated disc – neck
- Herniated disc – low back
- Osteoporosis / Osteopenia
- Fractures
- Carpal tunnel syndrome
- Thoracic outlet syndrome
- Rheumatoid arthritis
- Lupus
- Gout
- Fibromyalgia
- Migraine
- Frequent headaches
- TMJ
- Lyme disease
- Other

Digestive & Eliminary System

- IBS
- Frequent loose stools
- Frequent constipation
- Hiatal hernia
- Kidney disease
- Liver disease
- Urinary incontinence
- Disordered eating
- Other

Surgeries

Please list all surgical procedures with the approximate date or your age at the time.

HANDS-ON Physical Therapy

Financial Agreement, Assignment of Benefits, Patient Consent Form & Policies

With the execution of this document, the undersigned, in consideration for services rendered, hereby agree to the following:

- 1. Financial Agreement:** I agree to pay for all services rendered to me by HANDS-ON Physical Therapy (also referred to as HANDS-ON Therapy or Christine McKnight, PT). I understand that as a courtesy to its patients providing insurance/billing information, HANDS-ON Physical Therapy will submit claims to my health care plan or insurance company. I further understand, however, that I am responsible for payment of the balance owed. I agree that I am also responsible for any deductibles, coinsurance, copays, charges for noncovered services, charges deemed "medically unnecessary" or charges for which I have not obtained a properly authorized written referral, if required of my health plan. In the event that I am not currently enrolled as a member of a health care plan, I am personally responsible for all charges incurred for services.
- 2. Assignment of benefits:** I hereby assign to HANDS-ON Physical Therapy those insurance benefit payments due HANDS-ON Physical Therapy, and hereby authorize my insurance company to make payment directly to HANDS-ON Physical Therapy or Christine McKnight, PT. I understand that, regardless of this assignment, I remain primarily responsible to HANDS-ON Physical Therapy for payment of all actual charges. A carbon copy or photocopy of this assignment shall be as valid as the original.
- 3. Release of information:** I authorize HANDS-ON Physical Therapy to disclose all or part of my medical record to any insurance carrier, person, or corporation that is or may be liable under contract to HANDS-ON Physical Therapy, or to me, or to a family member or employer of mine, for all or part of HANDS-ON Physical Therapy's charges. This authorization includes but is not limited to, workers' compensation carriers, Anthem (Blue Cross), Blue Shield, commercial insurance carriers, and the fiscal intermediary under Medicare and Medicaid.
- 4. Patient consent:** Based on physician's referral for HANDS-ON Physical Therapy's services, I request and give consent to HANDS-ON Physical Therapy, its therapists, and staff to provide therapeutic services and related care.

Client & Therapist Agreement

The mission of HANDS-ON Physical Therapy is to create a healing experience through hands-on techniques, movement education, and open communication, while providing an environment that fosters each client's innate healing capacity.

I will communicate any changes in health insurance, address, phone number, or health condition as soon as possible.

I will give 48 hours' notice if I need to cancel or reschedule an appointment. HANDS-ON Physical Therapy charges a missed appointment fee when 48 hours' notice is not given; this fee is \$25 for 30-minute appointments and \$50 for 60-minute appointments.

I understand I may be released from care if missed visits interfere with the therapist's ability to provide appropriate and effective treatment.

I understand that everyone in this office will safeguard all patient files and information against loss, tampering, or use by unauthorized persons including any computerized information.

I understand that photographs may be taken as a visual aid for both myself and for my provider.

I authorize HANDS-ON Therapy to request any medical records pertaining to my treatment.

Any co-insurance or deductibles are due as incurred.

I have received the Notice of Privacy Practices and have been provided an opportunity to review it by HANDS-ON Physical Therapy.

My signature below acknowledges that I have been given the opportunity to read or have had the above information explained to me and that I fully understand the statements in this document and consent to each of them. I certify that I am the patient or am duly authorized by the patient to execute the above and I accept the terms.

Patient Name: _____

Patient Signature _____ **Date** _____

Patients' agent/representative/ guardian ____ Patient name: _____ Date: _____