Magna Physical Therapy &
Sports Medicine Center LLC

New Patient Forms

Name:_____ **Date of Birth:** _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Occupation: _____ Marital Status (check one): ☐ M ☐S ☐D ☐W

Emergency Contact: _____ Phone: _____

Relationship to Patient/Client: _____

Primary Care Doctor: _____ Phone: _____

Specialist Doctor: _____ Phone: _____

How did you hear about Magna Physical Therapy?

- Would you like to receive our PT and Wellness Newsletter? ☐**Yes** ☐**No**
- Would you like to receive our Dance Medicine Newsletter? ☐**Yes** ☐**No**
- Would you like information about our Personal Training, Massage Therapy, or Group Fitness/Pilates Programs? ☐**Yes** ☐**No**
- Do you wish to speak with a social worker at this time? ☐**Yes** ☐**No**

AUTHORIZATION OF PAYMENT: It is our policy that office visits are paid for at the time services are rendered, this includes copayments and deductibles. Once your insurance carrier processes your claim we will bill you for any remaining patient responsibility deemed by your insurance carrier. As a courtesy to you, we have verified the following coverage is offered to through your current insurance carrier:

COINSURANCE/CO-PAY: _____

DEDUCTIBLE: _____ AMOUNT REMAINING: _____

MAXIMUM PHYSICAL THERAPY BENEFIT: _____

I hereby authorize Magna Physical Therapy to release all information necessary, including medical records, to secure payment. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

**Note: Magna Physical Therapy does not accept responsibility for any incorrect information given by you or your insurance carrier regarding your insurance benefits or benefit plans.*

Client/Guardian Signature: _____ Date: _____

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Terms and Conditions

CONSENT TO TREATMENT: I agree and give my consent for Magna Physical Therapy to furnish rehabilitative care and related treatment to be considered necessary and proper in diagnosing or treating my physical condition. In so doing, I understand and acknowledge that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of a sensitive nature.

Initials: _____

LIABILITY: I know and agree that Magna Physical Therapy is not responsible for loss or damage to personal valuables that are brought with me during treatment at the facility.

Initials: _____

WAIVER AND RELEASE: I hereby release Magna Physical Therapy & Sports Medicine Center, LLC and its affiliated entities, employees, trustees and their respective representatives and agents from all claims, liabilities, and causes of action arising from or associated with my participation in this program.

Initials: _____

MEDICAL WAIVER: I understand that providing Magna Physical Therapy staff with current information about changes in my health, which includes any illness or symptoms I experience in the performance center or at home, is essential for the staff to determine if any modifications need to be made in my exercise program. I understand that if I do not inform the Magna Physical Therapy staff that I may be putting myself at risk for injury or serious medical problems. I understand that the staff has the right to address concerns about my health with my physician and may ask to temporarily discontinue or modify my treatment until my physician evaluates my condition and provides recommendations for care.

Initials: _____

NOTICE OF PRIVACY PRACTICES: I acknowledge receipt of Notice of Privacy Practices/Policies.

Initials: _____

CANCELLATION POLICY: I understand that I will be charged a $25.00 cancellation/No Show fee if I fail to keep an appointment without at least 24 hour notification.

Initials: _____

I, the undersigned, certify that all the information provided herein is true and correct to the best of my knowledge. I have reviewed the above policies and do hereby agree to abide by them to the best of my abilities.

Client/Guardian Signature: _____ Date: _____

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Medical History

Have you RECENTLY noted any of the following? (check all that apply)

- □ Headaches
- □ Fever/chills/sweats
- □ Nausea/vomiting
- □ Weight loss/gain
- □ Difficulty with balance
- □ Shortness of breath
- □ Numbness/tingling
- □ Muscle weakness
- □ Dizziness/lightheaded
- □ Heartburn/indigestion
- □ Difficulty swallowing
- □ Bowel/bladder changes
- □ Diarrhea or constipation
- □ Falls
- □ Fainting
- □ Cough
- □ Fatigue
- □ Infection

Have you EVER been diagnosed with any of the following conditions? (check all that apply)

- □ Allergies
- □ Anemia
- □ Anxiety
- □ Arthritis
- □ Bone/joint infection
- □ Asthma
- □ Autoimmune disorder
- □ Cancer
- □ Cardiac/heart problems
- □ Arrhythmia
- □ Chest pain/angina
- □ Pacemaker or defibrillator
- □ Chemical dependency
- □ Circulation/vascular problems
- □ Blood or clotting disorders
- □ Raynaud's disease
- □ Depression
- □ Diabetes
- □ Dizzy spells
- □ Emphysema/bronchitis
- □ Lung problems
- □ Pneumonia
- □ Fibromyalgia
- □ Fractures
- □ Gallbladder problems
- □ Headaches
- □ Hearing impairment
- □ Hepatitis
- □ Liver problems
- □ High cholesterol
- □ High blood pressure
- □ Low blood pressure
- □ Sexually transmitted infection
- □ Pelvic inflammatory disease
- □ HIV/AIDS
- □ Incontinence
- □ Kidney problems
- □ Urinary tract/bladder infection
- □ Metal implants
- □ MRSA
- □ Multiple sclerosis
- □ Muscular disease
- □ Osteopenia or osteoporosis
- □ Parkinson's
- □ Rheumatoid arthritis
- □ Seizures/epilepsy
- □ Smoking/tobacco use
- □ Speech problems
- □ Stroke
- □ Thyroid disease
- □ Tuberculosis
- □ Vision problems

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions? (check all that apply)

- □ Cancer
- □ Diabetes
- □ Tuberculosis
- □ High blood pressure
- □ Stroke
- □ Thyroid problems
- □ Heart problems
- □ Depression
- □ Blood clots

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During the past month have you been feeling down, depressed or hopeless? ☐**Yes** ☐ **No**

During the past month have you been bothered by having little interest or pleasure in doing things? ☐**Yes** ☐**No**

Is this something with which you would like help? ☐**Yes** ☐**No**

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ☐**Yes** ☐**No**

Have you received any of the following treatments in the past year?

Chiropractic	☐**Yes** ☐**No**	Speech Therapy	☐**Yes** ☐**No**
Home Care Physical Therapy	☐**Yes** ☐**No**	Occupational Therapy	☐**Yes** ☐**No**

Please list any allergies:

_____ Response: _____

_____ Response: _____

Please list any surgeries you have had:

_____ Date: _____

_____ Date: _____

_____ Date: _____

Please list any medications you are currently taking or attach a medication list:

Drug	Dose	Frequency	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever taken steroid medication for any medical condition? ☐**Yes** ☐**No**

Have you ever taken blood thinners or anticoagulants for any medical condition? ☐**Yes** ☐**No**

Are you currently pregnant? ☐**Yes** ☐**No**

Do you currently exercise? ☐**Yes** ☐**No**

If yes, what types and how often? _____

Weight: _____lbs Height: _____ft_____in

Client/Patient/Guardian Signature:

_____ Date: _____

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THE FOLLOWING ITEMS ARE SPECIFIC TO YOUR CURRENT INJURY/CONDITION

When did your current symptoms start? _____

What do you think caused your symptoms?

_____

My symptoms are currently: ☐**Getting Better** ☐**Getting Worse** ☐**Staying the Same**

I should avoid all physical activities that might make my pain worse:

☐**Disagree** ☐**Agree** ☐**Unsure**

Treatment received so far for this problem, with dates (chiropractic, injections, etc):

_____

Please list any tests performed for this problem, with dates (x-ray, MRI, labs, etc):

_____

Have you ever had this problem before? ☐**Yes** ☐**No**

Did you have treatment? ☐**Yes** ☐**No**

How long did it take for you to feel better? _____

Are you currently able to sleep at night due to your symptoms?

☐**No problem sleeping** ☐**Difficulty falling asleep**

☐**Awakened by pain** ☐**Sleep with medication**

When are your symptoms worse?

☐**Morning** ☐**Afternoon** ☐ **Evening** ☐**Night** ☐**After exercise**

When are your symptoms better?

☐**Morning** ☐**Afternoon** ☐**Evening** ☐ **Night** ☐**After exercise**

How often do you experience your symptoms?

☐**Constantly** ☐**Frequently** ☐**Occasionally**

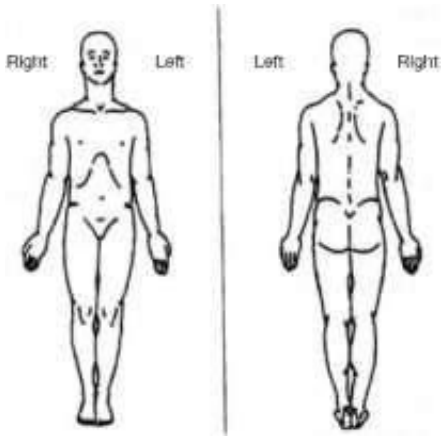
Using the 0 to 10 scale with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:

Your current level of pain right now: **____/10**

The best your pain has been during the last 24 hours: **____/10**

The worst pain has been during the past 24 hours: **____/10**

Please indicate on the diagram to the right where you feel your pain. →



Client/Patient/Guardian Signature:

_____ Date: _____

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I, (print name) _____, understand that the following services and/or treatment will not be covered by my insurance and payment will be due on the date of service rendered:

- Dry Needling - $50
  - In conjunction with PT services - $35
- Ionto - $12
- Stim pads/Electrodes - $5+tax (one clinic one time charge only)

  ***Patients maintaining appointments in both Avon and Canton clinics will be charged $7.50 + tax allowing us to keep a set of pads in each location.

Payment can be made by cash, check, or credit card (Visa, MasterCard, and Discover accepted).

I have read and understand the above information that I will be responsible for the out-of-pocket fees associated with each applicable date of service.

Patient/Client/Guardian SIGNATURE: _____

Date: _____