308 S.E. Greenville Blvd., B-3
Greenville, NC 27858
Phone: 252.215.5225
Fax: 252.215.5226

NEW PATIENT INFORMATION

Patient's Full Legal Name:

_____Sex (circle): Female Male
Last First Middle Initial

Date of Birth: _____/_____/_____ Age: _____ SSN: _____

Address: _____
Street City State Zip

Home Phone: ( ) _____ Work Phone: ( ) _____

Cell Phone: ( ) _____ Check preferred method of contact for appointment reminders:

E-mail: _____ Email_____ Phone_____ Text_____

Patient Status: Single: _____ Married: _____Other: _____

Do you live: alone _____ with a spouse/partner: _____ with other:_____

Employment: Employed: _____ Retired: _____Student: _____Disabled: _____

Occupation: _____

Employer's name: _____

Referring Physician: _____ Phone number: _____

Reason for seeking Physical Therapy: _____
(Diagnosis)

Emergency Contact: _____ Phone number:_____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder's Name: _____

Policy Holder's SSN: _____ Policy Holder DOB: _____

Secondary Insurance: _____

Policy Holder's Name: _____

Policy Holder's SSN: _____ Policy Holder's DOB: _____

MEDICAL HISTORY

***The therapist will discuss your medical/social history in detail on your first visit, but this form creates a great starting point. Please try to include as much information as possible.**

Please describe the current problem that brought you here:

_____

_____

When did it first begin? _____

What activities make your symptoms worse? Check all that apply:

___ Sitting ___ Light Housework ___ Sit to Stand
___Walking ___Vigorous Exercise ___ Sexual Activity
___Standing ___Lifting/Bending Other, please list_____

What makes your symptoms better? Check all that apply:

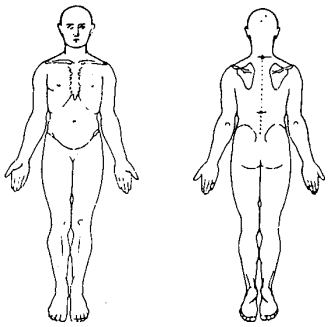
___ Prescription Pain Medication ___Exercise/Stretching ___ Ice/Heat
___Non-Prescription Pain Medication ___Sitting/Lying down Other, please list_____

What meaningful tasks or activities do you want to do but cannot at this time?

_____

_____

How would you rate your pain today? 0 1 2 3 4 5 6 7 8 9 10
None Severe



Please shade the area where you experience pain

Do you exercise? Yes / No If yes, how often and what type of exercise? _____

Current Height: _____ Current Weight: _____ Do you smoke? Yes / No

Have you had any falls in the past 12 months? Yes/No If yes, how many: _____

Stress Level: Low Medium High

Please explain stressors:

_____

_____

Please list any physical therapy you have had in the past (include dates):

_____

_____

Please list your surgical history:

_____

_____

Do you have a Latex Allergy? Yes / No

Current Medications:

Drug Name:	Reason:	Drug Name:	Reason:
1.		**6.**	
2.		**7.**	
3.		**8.**	
4.		**9.**	
5.		**10.**	

Please circle all that apply:

Seizures	Back/Neck Pain	Migraine
Heart Disease	Scoliosis	Painful Intercourse
High Blood Pressure	Diabetes	Sexual Abuse
Pacemaker	Thyroid Condition	IBS
Stroke	Neurologic Disease	Erectile Dysfunction
Lung Disease	Cancer _____ (type)	Sexually Transmitted Disease
Osteoporosis/Osteopenia	Depression/Anxiety	Groin Pain
Arthritis	Memory Deficits	Urine or Bowel Leakage
Fibromyalgia	Kidney Disease	Abdominal Pain
High Cholesterol	Recurrent Infections	Other:_____

***If you are female please also complete the follow questions:**

Are you pregnant? Yes / No If so, how many weeks? _____

# of pregnancies: _____ Vaginal Deliveries: _____ C-Sections: _____ Weight of largest baby: _____

# of episiotomies: _____ # of tears: _____ Painful Menses? Yes/No

Do you have a painful C-section scar? Yes / No

Have you experienced menopause? Yes / No If yes, approximate date of onset? _____

Is there anything else you would like me to know?

_____

_____

PATIENT SIGNATURE: _____ Date: _____

PRIVACY ACT

I authorize Avila Physical Therapy for Women's Health, Inc. to release or obtain medical or other information necessary to provide my treatment and process the insurance claim. I understand this information will not be shared unnecessarily and that my personal information is protected under the Privacy Act in which this office abides (copy available upon request).

Sign: _____ **Print:** _____

DOB: _____ **Date:** _____

CONSENT FOR TREATMENT

I consent to Physical Therapy services at Avila Physical Therapy for Women's Health, Inc. In doing so, I understand that such therapy may involve bodily contact, touching and/or direct contact of a sensitive nature. I understand that these procedures will be fully explained before they are provided and that I have the right to refuse or stop any treatment at any time without fear of judgment or other repercussions.

Patient Initials: _____

ATTENDANCE POLICY

Regular attendance to your appointments is crucial to your success. Please provide 24 hour notice if you are unable to keep your appointment. Failed appointments, or those cancelled after 24 hours, will be charged a $50 cancellation fee. You are responsible for paying this fee at your next appointment, or a statement will be sent the next billing cycle. Repeated missed or cancelled appointments will result in reevaluation of your therapy needs. Emergencies or weather cancellations will not be charged the cancellation fee. Active therapy requires visits to be spaced no more than 30 days apart. If you do not attend therapy within 30 days of your last appointment, you must obtain another referral from your doctor.

Patient Initials: _____

BILLING POLICY

I authorize Avila Physical Therapy for Women's Health, Inc. to bill my insurance company directly for the covered portion of charges, and I authorize payment of medical benefits directly to Avila Physical Therapy for Women's Health, Inc. If my insurance company reimburses me directly for any services that I have not already paid for, I am responsible to remit payment in full to Avila Physical Therapy for Women's Health, Inc.

I understand that I am ultimately responsible for my physical therapy charges and agree to pay my deductible, copayment, and any charges not reimbursed by my insurance carrier. I understand that some insurance companies require preauthorization, or have reimbursement limits on Physical Therapy. I understand that I am responsible for knowing and meeting these requirements.

I agree to pay my portion of the daily charges at the time of service. I agree to pay all other charges within 30 days of receiving the bill. I understand I may pay these charges by cash, check, or credit/debit card. Failure to pay outstanding balances in a timely manner, usually 3 months after discharge from therapy, will result in the practice forwarding my account to an outside collection agency which may result in additional administrative fees. Payment plans are available through Care Credit.

Patient signature: _____ **Date:** _____