State-of-the-Art Physical Therapy

2492 Walnut Avenue, #140 * Tustin, CA 92780
(714)544-2188 * (714)544-2189 Fax
sotapt@sbcglobal.net * www.sotapt.com

Name (Last, First, Middle)_____ **Insured's Name** (Last, First, Middle)_____

Address_____ **Address**_____

City, State, Zip_____ **City, State, Zip**_____

Social Security #_____ **Social Security #**_____

Date of Birth_____ **Date of Birth**_____

Phone (home)_____ **Phone** (home)_____

Phone (wireless)_____ **Phone** (wireless)_____

E-mail_____ **E-mail**_____

Preferred Appt Confirmation Method (please check one):

Employer_____ **Phone ___ E-Mail ___ Text ___**

Address_____ **Height**_____**Weight**_____**Male**_____**Female**_____

City, State, Zip_____ **Married**_____**Single**_____**Divorced**_____

Phone_____ **Occupation**_____**Sport(s)**_____

Emergency Contact Name:_____ **Date of injury**_____

Emergency Contact Number:_____ **Area of injury**_____

Referring Doctor_____ **Insurance**_____

Address_____ **Address**_____

City, State, Zip_____ **City, State, Zip**_____

Phone_____ **Phone**_____

Specialty_____ **Policy#**_____

I consent to physical therapy services rendered at State-of-the-Art Physical Therapy. I also consent to physical therapy services rendered at State-of-the-Art Physical Therapy of my minor child in my absence. Name of minor child_____ Initials_____

I understand that it is my responsibility to inform the physical therapist/staff about any health problems or allergies I have as well as any drugs or medications I am taking. I understand that the practice of physical therapy is not an exact science and that no guarantees or promises have been made to me as a result of treatments or examinations by the physical therapist or supportive personnel. I understand that no contract, warranty, guarantee, or promise concerning the results of the physical therapy services is made. Initials_____

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed above and certify that this information is true and correct to the best of my knowledge. I will notify the office of any changes in my status or any changes in the above information as soon as possible. I AM AWARE AND UNDERSTAND THAT IF ANY CHECKS ARE MAILED TO MY HOME, I SHALL PROMPTLY DELIVER THE CHECK TO STATE-OF-THE-ART PHYSICAL THERAPY. IF CHECKS ARE NOT DELIVERED, I WILL BE RESPONSIBLE FOR ALL CHARGES IN FULL. I hereby authorize State-of-the-Art Physical Therapy to furnish my insurance carrier or others with full information regarding treatment rendered when so requested. I hereby authorize direct payment of my insurance benefits to State-of-the-Art Physical Therapy, otherwise payable to me, for services rendered. I agree that a copy of this letter is as valid as the original.
Initials_____

Signature_____ **Date**_____

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Confidential Health History

Medications: List all medications you are currently taking

_____

_____

Allergies: List all allergies

_____

_____

Medical History: Check the medical conditions you have or have had in the past

__ AIDS
__ Alcoholism
__ Anemia
__ Anorexia
__ Appendicitis
__ Arthritis
__ Asthma
__ Bleeding Disorders
__ Breast Lump
__ Bronchitis
__ Bulimia
__ Cancer
__ Cataracts
__ Chemical Dependency
__ Chicken Pox
__ Diabetes
__ Emphysema
__ Epilepsy
__ Gall Bladder Disease
__ Glaucoma
__ Goiter
__ Gonorrhea
__ Gout
__ Heart Disease
__ Hepatitis
__ Hernia
__ Herpes
__ High Cholesterol
__ HIV Positive
__ Kidney Disease
__ Liver Disease
__ Measles
__ Migraine Headaches
__ Miscarriage
__ Mononucleosis
__ Multiple Sclerosis
__ Mumps
__ Pacemaker
__ Pneumonia
__ Polio
__ Prostate Problem
__ Psychiatric Care
__ Rheumatic Fever
__ Scarlet Fever
__ Stroke
__ Suicide Attempt
__ Thyroid Problems
__ Tonsillitis
__ Tuberculosis
__ Typhoid Fever
__ Ulcers
__ Venereal Disease

Symptoms: Check the symptoms you currently have or have had in the past year

GENERAL:
__ Chills
__ Depression
__ Dizziness
__ Fainting
__ Fever
__ Forgetfulness
__ Headache
__ Loss of sleep
__ Loss of weight
__ Nervousness
__ Numbness
__ Sweats

CARDIOVASCULAR:
__ Chest pain
__ High blood pressure
__ Irregular heartbeat
__ Low blood pressure
__ Poor circulation
__ Rapid heartbeat
__ Swelling of ankles
__ Varicose veins

MUSCLE/JOINT/BONE:
(pain, weakness, numbness in)
__ Arms
__ Legs
__ Hands
__ Feet
__ Neck
__ Back

GENIOT-URINARY:
__ Blood in urine
__ Frequent urination
__ Lack of bladder control
__ Painful urination

SKIN:
__ Bruise easily
__ Hives
__ Itching
__ Change in moles
__ Rash
__ Scars
__ Sores that won't heal

GASTROINTESTINAL:
__ Appetite poor
__ Bloating
__ Bowel changes
__ Constipation
__ Diarrhea
__ Excessive thirst
__ Gas
__ Hemorrhoids
__ Indigestion
__ Nausea
__ Rectal bleeding
__ Stomach pain
__ Vomiting including blood

WOMEN:
__ Breast lump
__ Extreme menstrual pain
__ Hot flashes
__ Currently pregnant

EYE, EAR, NOSE THROAT:
__ Bleeding gums
__ Blurred vision
__ Crossed eyes
__ Difficulty swallowing
__ Double vision
__ Earache
__ Ear discharge
__ Hay fever
__ Hoarseness
__ Loss of hearing
__ Nosebleeds
__ Persistent cough
__ Ringing in ears
__ Sinus problems
__ Vision – flashes or halos

*Interested in weight loss? Yes No

*Interested in nutritional supplements for optimal health? Yes No

State-of-the-Art Physical Therapy has my authorization to request from a personal physician, hospital, clinic, etc. information regarding my medical history, physical condition or diagnosis when deemed necessary.
To the best of my knowledge, the foregoing are correct and complete.

Name_____ Date_____

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HOW DID YOU FIND OUT ABOUT US?

This information is used to help us service our clients better.
(Please Print)

Your name: _____ Date: _____

(Please Check and Complete all that Apply)

- ☐ Referred by a friend or family member. Name: _____
- ☐ Referred by Dr or other health care professional: Name: _____
- ☐ Referred by a current or former patient of SOTA PT. Name: _____
- ☐ Web site search. Search term: _____

Browser used (circle one): Google / Yahoo / Bing / Chrome / Other

Web site or web link (check all that apply):

- ☐ www.sotapt.com
- ☐ www.tustinphysicaltherapist.com
- ☐ www.physicaltherapists.com
- ☐ Yelp Link
- ☐ Alter G Website Link
- ☐ K-Laser Website Link
- ☐ Other Website Link: Name: _____
- ☐ Other Method: _____

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PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Date of Birth _____

Signature _____

Date _____

Cancellation/No Show Policy

I agree to inform State-of-the-Art Physical Therapy of my cancellation by 7:00 PM the business day prior to my appointment. Should I miss my appointment at State-of-the-Art Physical Therapy or fail to inform them within the time frame referenced above, I understand that I will be responsible for a $20 fee per incident.

Patient Name (Print) _____

Patient's Legal Guardian _____

Signature _____ **Date** _____