Outpatient Physical Therapy Attendance Agreement

I understand that my involvement in therapy and the completion of my home exercise program is critical to maximize my potential for meeting my therapy goals.

Furthermore, I understand that my attendance is a critical part of my success.
If I must cancel an appointment I will do so at least 24 hours prior to the appointment.
My therapist (s) and I will make every effort to reschedule that session for the same week.

If I am unable to give 24 hours notice, I will still inform my therapist that I will be unable to attend prior to the session. I understand that if I am unable to attend my therapy at the rate stated below, my therapy be decreased or discontinued.

Patient	Cancellations (<24 hrs notice)	No shows
Adult (18 years +)	2 out of 15 sessions	Any 3 sessions
Pediatric (<18 years)	3 out of 15 sessions	Any 3 sessions

To provide notification of cancellation, please call: (239) 254-9798 Creekside
(239) 643-8766 Commons

Worker's Comp Patients: I understand that failure to meet the expectations of regular attendance will result in notification of my Worker's Comp Case Manager.

Patient Signature:_____________________________ Date:_____________

Therapist Signature:___________________________ Date:_____________

NCH Healthcare Group

Physical Therapy

Medical History Form

Date:____________________

Name:____________________________ **Phone:**____________________________

Thank you for answering the following questions so that we can administer your treatment safely and effectively.

Date of Birth:______________________

For what problem have you been referred to physical therapy?

Who referred you to our clinic?

How and when did injury occur?____

Date of last hospitalization:____

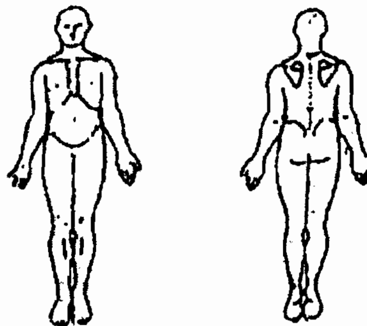
Date of surgery related to this problem:____________________________________

List any other surgeries you have had in the past 5 years:

Date of last admission to nursing home:____________________________________

How is your current injury restricting your daily activities? (i.e, walking,dressing,driving, sports,activities,etc.)

Where is your pain? Please mark on the drawing below the areas where you feel pain.



Please rate your pain on a scale 0-10:

NO PAIN 1 2 3 4 5 6 7 8 9 10

Please fill out page 2.

DO YOU HAVE ANY OF THE FOLLOWING?(circle yes or no)

CARDIAC PACEMAKER/DEFIBRILLATOR	yes	no
METAL IMPLANTS OF ANY KIND	yes	no
DIABETES	yes	no
HEART PROBLEMS	yes	no
CONVULSIONS OR SEIZURES	yes	no
HIGH BLOOD PRESSURE	yes	no
OSTEOPOROSIS	yes	no
RHEUMATOID ARTHRITIS	yes	no
Are you currently being treated by a Chiropractor	yes	no
Are you allergic to any drugs, adhesive tape or disinfectant substance	yes	no

List any medications you are currently taking:

List any other problems:

Have you had any prior PT for any problem during the past calendar year in an outpatient setting?

If yes, list dates and describe the treatment you received?

Would it be ok to contact your home phone or cell phone if needed?
Leave a message?

To properly insure that we submit to the correct insurance company we will need the following information.

How are we billing for your services today? Pleas circle one of the following:

Medicare Primary **Commercial Ins**

Workman's Comp **Auto Insurance**

Cash

Signature of patient or representative **Date:**