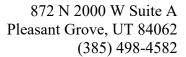


872 N 2000 W Suite A Pleasant Grove, UT 84062 (385) 498-4582

First Name:	PATIENT INFORMATION										
Birth Date:	First Name:	Last Name:			Mi		Middle Initial:		Date: / /		/
Rith Date:	Address:	ddress:			City: State:				:	Zip:	
Chose Clinic Because/ Referred to Clinic by Dr.	Email Address:										
Chose Clinic Because/ Referred to Clinic by Dr.:	Birth Date: / /	Age:		☐ Ma	ale 🗌 Fen	nale		S.S. #:	-	-	
Tama Former Patient	Home Phone: () -	Al	ternative Phone	e (Cell, Pag	ger): ()	-		Spouse	:		
MORK INFORMATION	Chose Clinic Because/ Referred to Clinic by Dr.:										
Employer:	☐ I am a Former Patient ☐ Close to Work/Home ☐ Web Search/Website ☐ Drive-by ☐ Advertisement										
Care Provider Information	WORK INFORMATION										
Proper	Employer:					Work P	hone: ()	-		Ext.
Regular Dr./PCP	Occupation:		Employment	Status _	Full Time	Part T	ime 🗌 R	etired [] Not Emplo	yed	
Regular Dr./PCP	CARE PROVIDER INFORMATION										
Primary Insurance Name: Subscriber's Name (If different): Sirth Date:	Referring Dr:				Phone: ()	-				
Primary Insurance Name: Subscriber's Name (If different): Birth Date: / / / ID. #: Group/Policy #: Policy Holder's SSN: SSN: Patient's Relationship to Subscriber: Self Spous Child Other: Name of Secondary Insurance: Birth Date: / / / Subscriber's Name: Group/Policy # Birth Date: / / / Patient's Relationship to Subscriber: Self Spous Child Other: AUTO OR WORK INJURY CLAIM VLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP) Insurance Name: Auto: Labor & Labor	Regular Dr./PCP				Phone: ()	-				
Subscriber's Name (If different):	INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)										
ID. #:	Primary Insurance Name:										
Patient's Relationship to Subscriber: Self Spouse Child Other:	Subscriber's Name (If different):						Birth Date:	/	/		
Name of Secondary Insurance: Birth Date: / / / Subscriber's Name: Group/Policy # Patient's Relationship to Subscriber: Self Self Spouse Child Other: AUTO OR WORK INJURY CLAIM PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP) Insurance Name: Auto: State: Self Subscriber: Self Subscriber: Self State: Self Subscriber: Self State: Self Subscriber: Self Subscrib	ID. #: Policy Holder's SSN:										
Subscriber's Name: Birth Date: / / / ID. #: Group/Policy # Patient's Relationship to Subscriber: Self Spous Child Other: AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE YOUR INJURY NATION FOR BACKUP) Insurance Name: Auto: Labor & Industries: Labor & Industries: Ext.: Ext.: Insurance Name: State: Zip: Insurance Name: Insura	Patient's Relationship to Subscriber: Self Spouse Child Other:										
Name:	Name of Secondary Insurance:										
Patient's Relationship to Subscriber: Self Spouse Child Other: AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP) Insurance Name: Auto: Labor & Industries: Ext.: Adjuster/Claim Manager: Address: City State: Zip: Ext.: Address: City State: Zip: Claim#: Cause: IN CASE OF EMERGENCY Name of Local Relative or Friend: Home Phone: -	Subscriber's Name:								Birth Date:	/	/
AUTO OR WORK INJURY CLAIM Surance Name: Auto: Labor & Industries: Phone: State: Zip: Adjuster/Claim Manager: City State: Zip: Claim #: Accident Date: / / Cause: Cause: IN CASE OF EMERGENCY Cause: Cause:	ID. #:		Group/Policy	<i>i</i> #							
Insurance Name:											
Adjuster/Claim Manager: Address: City State: Zip: Claim #: Name of Local Relative or Friend: Relationship to Patient: Home Phone: Relationship to Patient: Relations											
Address: City State: Zip: Claim #: Name of Local Relative or Friend: Relationship to Patient: Home Phone: () - Please provide the name of the person(s) to whom Weiss Physical Therapy Associates, P.C. may disclose health information Name: Relationship to Patient: Phone: () -	Insurance Name: Auto:		Labor & I	ndustries:		,					
Claim #: Accident Date: / / Cause: IN CASE OF EMERGENCY Name of Local Relative or Friend: Relationship to Patient: Home Phone: () - Work Phone: () - Please provide the name of the person(s) to whom Weiss Physical Therapy Associates, P.C. may disclose health information Name: Relationship to Patient: Phone: () -	Adjuster/Claim Manager:					Pho	one:				Ext.:
IN CASE OF EMERGENCY Name of Local Relative or Friend: Relationship to Patient: Home Phone: () - Work Phone: () - Please provide the name of the person(s) to whom Weiss Physical Therapy Associates, P.C. may disclose health information Name: Relationship to Patient: Phone: () -	Address:			City			Sta	te:		Zip:	
Name of Local Relative or Friend: Relationship to Patient: Home Phone: () - Work Phone: () - Please provide the name of the person(s) to whom Weiss Physical Therapy Associates, P.C. may disclose health information Name: Relationship to Patient: Phone: () -	Claim #:	Ac	cident Date:	/	/		Cause	:			
Relationship to Patient: Home Phone: () - Work Phone: () - Please provide the name of the person(s) to whom Weiss Physical Therapy Associates, P.C. may disclose health information Name: Phone: () - Phone: () -	IN CASE OF EMERGENCY										
Please provide the name of the person(s) to whom Weiss Physical Therapy Associates, P.C. may disclose health information Name: Relationship to Patient: Phone: () -	Name of Local Relative or Friend:										
Name: Relationship to Patient: Phone: () -	Relationship to Patient:	Но	ome Phone: () -			Work	Phone: () -		
	Please provide the name of the person(s) to whom Weiss Physical Therapy Associates, P.C. may disclose health information										
May we send an email or leave messages regarding appointments or treatment on your answering machine? Yes	Name:	me: Relationship to Patient:			Phone: () -						

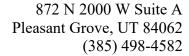
I have read and agree to the above, including the authorization to disclose my health information to the named recipient(s). Additionally, I authorize my insurance benefits be paid directly to Timpanogos Physical Therapy and authorize said practice to release any information required to process my claim. I understand that I am financially responsible for any remaining balance.





PAST MEDICAL HISTORY FORM			Patient Name		
BLOOD PRESSURE	YES	NO	JOINT CONDITIONS	YES	NO
High Blood Pressure			Upper Extremity Dislocation		
Low Blood Pressure			Lower Extremity Dislocation		
		_	Rheumatoid Arthritis	\Box	\Box
			Osteoarthritis		一
HEART DISEASE	YES	NO	OTHER CONDITIONS	YES	NO
Heart Attack	\Box		Carpal Tunnel R/L	П	П
Atherosclerotic Disease	Ħ	Ħ	Parkinson's Disease	Ħ	Ħ
Arrhythmia(s)	H	H	Multiple Sclerosis	H	H
Rheumatic Heart Disease	H	H	Epilepsy	H	H
Heart Murmur	H		Gout	H	H
Do you have a pacemaker?	H	H	Fibromyalgia	H	H
MUSCLE CONDITION	YES	NO	Diabetes	H	H
Tennis Elbow R/L				H	H
Back/Neck Problems	H	H	Hearing Loss	H	H
	H	H	Poor Eyesight	H	님
Muscular Dystrophy Limited Limb Movement	H	H	Fainting Polio	H	H
	N/EC	NO		H	H
LUNGS	YES	NO	High Cholesterol	님	님
Asthma	님	\vdash	Osteoporosis	닏	님
Emphysema	닏		Anxiety	닏	닏
COPD	닏	\vdash	Cancer	닏	닏
Shortness of Breath			Depression		\sqcup
			Stroke	닏	\sqcup
			Thyroid Condition		
			Other:		
EXERCISE WORK ACT	ΓΙVΙΤΥ	STRE	SS LEVEL	HABITS	
EXERCISE WORK ACT	ΓΙVΙΤΥ	STRE	SS LEVEL Smoking	HABITS Packs a D	av
None Sitting	ΓΙVΙΤΥ	Low	☐ Smoking	Packs a Da	
None ☐ Sitting ☐ 1-2 x Week ☐ Standing	TIVITY	Low Medi	☐ Smoking um ☐ Alcohol	Packs a Darinks a V	Veek
None ☐ Sitting ☐ 1-2 x Week ☐ Standing ☐ 3-4 x Week ☐ Light Labor		Low	☐ Smoking	Packs a Da	Veek
□ None □ Sitting □ 1-2 x Week □ Standing □ 3-4 x Week □ Light Labor □ 5+ x Week □ Heavy Labor		Low Medi	☐ Smoking um ☐ Alcohol	Packs a Darinks a V	Veek
None ☐ Sitting ☐ 1-2 x Week ☐ Standing ☐ 3-4 x Week ☐ Light Labor ☐ 5+ x Week ☐ Heavy Labor ☐ Other		Low Medi	☐ Smoking um ☐ Alcohol	Packs a Darinks a V	Veek
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None ☐ Sitting ☐ 1-2 x Week ☐ Standing ☐ 3-4 x Week ☐ Light Labor ☐ 5+ x Week ☐ Heavy Labor ☐ Other		Low Medi	☐ Smoking um ☐ Alcohol	Packs a Darinks a V	Veek
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None Sitting 1-2 x Week Standing 3-4 x Week Light Labor 5+ x Week Heavy Labor Other What types of exercise do you perform? What things cause stress in your life?		Low Medi	☐ Smoking ☐ Alcohol ☐ Coffee/Soda	Packs a Da Drinks a V	Veek
None Sitting 1-2 x Week Standing 3-4 x Week Light Labor 5+ x Week Heavy Labor Other What types of exercise do you perform?		Low Medi	☐ Smoking um ☐ Alcohol	Packs a Da Drinks a V	Veek
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Date First Symptom of Yo									
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Plea	se circle on	the scale be	elow to	indicate	your <u>(</u>	CURRE	NT leve	el of pai	in:
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No Pain 0 1	2	3 4	5	6	7	8	9	10	Pain as bad as it get
Additional Comments:									
What goals do you wish to achieve t	in physical there	apy?							





CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information will be used by this practice, known as <u>Timpanogos Physical</u> <u>Therapy</u> or disclosed to others for the purpose of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

We are providing you with a copy of our Notice of Privacy Practices. We request that you review the notice prior to signing this consent. You may request a restriction on the use or disclosure of your protected health information. If you wish to restrict your disclosure, you should make that request in writing.

This practice, however, may or may not agree to restrict the disclosure of your protected health information.

If we agree to your request, the restrictions will be binding. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

You may revoke the consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received will not be affected.

This practice reserves the right to modify the privacy practices outlined in the notice.

SIGNATURE

I have reviewed this consent form and have reviewed the Notice of Privacy Practices. I give my permission to this practice to use and disclose my health information in accordance with it.

Name of Patient (Print Clearly)	
Signature of Patient	Date
Signature of Patient Representative	
Relationship of Patient Representative to Patient	