Pursuit
PHYSICAL THERAPY
Pursuing....Better Outcomes, Faster Results, and a Better Quality of Life

Patient Information

Patient Name: _____
(First) (M.I.) (Last) (Nickname)

Address: _____

City: _____State: _____Zip Code: _____

Home or Cell Phone: _____Age _____

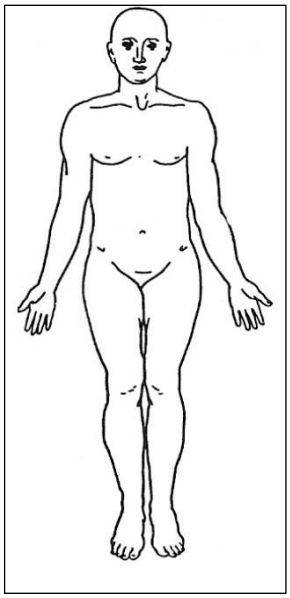
Date of Birth: _____Occupation: _____

Physician: _____Insurance Co._____

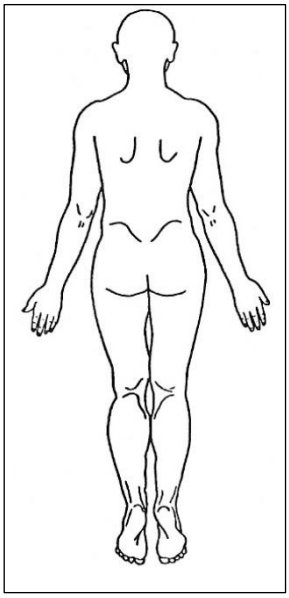
Yearly Deductible: _____Do you have an HSA/FSA? ☐ Yes ☐ No

Patient Health Questionnaire

Please mark on the diagram below where you are experiencing your symptoms and pain. Use the key to indicate which type of symptoms.



Deep Ache = ZZZZ
Sharp/Stabbing = ////
Pins and needles = 0000
Burning = XXXX
Throbbing = ++++



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Have you been seen by a medical professional already for your pain? ☐ Yes ☐ No

If yes, please mark all that apply:

☐ Primary Doctor	☐ Dentist	☐ Acupuncture
☐ Chiropractor	☐ Physical Therapy	☐ Nurse Practitioner
☐ Ortho Surgeon	☐ ER	☐ Other

When did your current pain begin/start? _____

What started or initially caused your pain?_____

_____

Are your symptoms getting: ☐ Better ☐ Worse

What activities/movements/positions increase your pain? _____

_____

What activities/movements/positions decrease your pain? _____

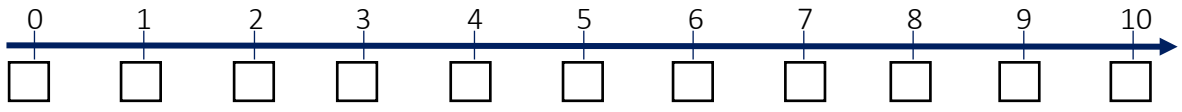
_____

Are you taking medications for your pain? (If yes, please list all medications) ☐ Yes ☐ No

_____

_____

On a **zero** to **ten** Scale (0 = no commitment/10 = fully committed), how committed are you to resolve your pain?



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Are you currently experiencing or do you have any history of the following?

Conditions	*I have none of these conditions:* ☐	
High blood pressure	☐Yes	☐No
Heart disease	☐Yes	☐No
Peripheral vascular disease	☐Yes	☐No
Pacemaker	☐Yes	☐No
Spinal Cord Stimulator	☐Yes	☐No
Stroke/TIA	☐Yes	☐No
Lung Disease/COPD	☐Yes	☐No
Blood clots	☐Yes	☐No
Blood thinners	☐Yes	☐No
Osteoporosis	☐Yes	☐No
Osteoarthritis	☐Yes	☐No
Rheumatoid arthritis	☐Yes	☐No
Autoimmune disease	☐Yes	☐No
Diabetes	☐Yes	☐No
Kidney disorder	☐Yes	☐No
Thyroid disorder	☐Yes	☐No
Stomach ulcers	☐Yes	☐No
Hepatitis	☐Yes	☐No
Cancer	☐Yes	☐No
Pregnancy	☐Yes	☐No
Asthma	☐Yes	☐No
HIV	☐Yes	☐No

Symptoms	*I have none of these symptoms:* ☐	
Dizziness	☐Yes	☐No
Recent fever, chills, sweats	☐Yes	☐No
Depression	☐Yes	☐No
Visual Disturbances	☐Yes	☐No
Ringing in ears	☐Yes	☐No
Hearing loss	☐Yes	☐No
Nausea	☐Yes	☐No
Unexplained weight changes	☐Yes	☐No
Headache	☐Yes	☐No
Difficulty swallowing	☐Yes	☐No
Night pain	☐Yes	☐No
Chest pain	☐Yes	☐No
Shortness of breath	☐Yes	☐No
Bowel and bladder difficulty	☐Yes	☐No
Urinary tract infection	☐Yes	☐No
Upper respiratory infection	☐Yes	☐No
Social History		
Do you sleep well?	☐Yes	☐No
Do you drink alcohol?	☐Yes	☐No
Do you use tobacco?	☐Yes	☐No
Do you exercise regularly?	☐Yes	☐No

If **yes** to any condition above, please explain: _____

_____

_____

List any known allergies: _____

List any previous surgeries: _____

_____

I authorize that the information in this Patient Health Questionnaire form is true to my knowledge.

Patient/Guardian Signature: _____

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Payment for Services Rendered

Pursuit Physical Therapy does not have a relationship with any health insurance and is a private-pay clinic. There are no insurance limitations, co-pays, deductibles, or miscellaneous bills needed with this service. It is the patient's responsibility to pay for the services provided with cash, check, credit card, debit card, flexible spending accounts, health savings accounts, or financing through Care Credit.

You may, depending on your health insurance, submit a claim to your health insurance company for reimbursement after services are completed. Pursuit Physical Therapy will provide a reimbursement form for you after your treatment plan is completed, which is necessary for you to submit a claim to your insurance company.

If you purchase a treatment package, you have a money back guarantee that can be accepted within the first 4 treatment sessions and your amount will be refunded to you.

I agree and understand the above statements.

Patient/Guardian Signature: _____ Date _____

Emergency Contact

In case of an emergency, we should contact:

Name: _____

Relationship: _____

Phone Number: _____

Testimonial Approval

After we accomplish all of your goals and the results we initially promised at the evaluation, we like to share our patient success stories as a testimonial. Of course, with your permission first!

"I hereby authorize Pursuit Physical Therapy to use and publish my testimonial that may contain my image, my content, and likeness. I agree and understand I shall neither be compensated for the content nor receive attribution for the content. I also attest that I am authorized to grant the right to use this content. I understand that this content may be used in publications, press releases, marketing materials, advertisements (both digital and print), websites (including social media sites), or other uses. This authorization is continuous, and only I may withdraw this authorization through specific, written rescission."

I agree with and understand the above statement: ☐ Yes ☐ No

Cancellation and Late Policy

CANCELLATIONS: There is no cancellation fee if you happen to cancel an appointment or evaluation.

LATE EVALUATIONS: If you are late to an evaluation, you can contact Pursuit Physical Therapy directly at 407-494-8835 and decide whether you would like to continue with the evaluation or reschedule. If you are < 15 min late, the duration of the evaluation will still end on the scheduled time and cost will still be the same to complete the evaluation. If you are > 15 min late, it is left up to the discretion of the therapist regarding rescheduling versus completing a shorter evaluation with less or no treatment. The eval will still end at the scheduled time and the cost is the same.

LATE TREATMENT APPOINTMENTS: If you are going to be late to a treatment appointment, you can contact Pursuit Physical Therapy directly at 407-494-8835 and decide whether you wish to continue with your appointment or reschedule. If greater than 15 minutes, you can reschedule or choose to pursue a shorter treatment, but the session will still end at the same scheduled time.

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Informed Consent to Physical Therapy Evaluation and Treatment

I hereby consent to evaluation and/or treatment of my condition by a licensed physical therapist employed by Pursuit Physical Therapy, PLLC.

The physical therapist has fully explained to me the nature and purposes of the procedures, evaluation and course of treatment.

The physical therapist has informed me of expected benefits and possible complications or discomfort, which may result from skilled physical therapy care. In addition, the physical therapist has explained to me the risks of receiving no treatment.

I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in a reasonable time period, I agree to contact my physical therapist.

I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

The physical therapist has explained that there is no guarantee that the proposed course of treatment will improve my condition and that it is possible, although unlikely, that the course of treatment may cause additional pain or discomfort or aggravate my condition.

In order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

The term “informed consent” means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning treatment and options available for my condition.

I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent form. In the event of a change in medical status, I understand that my treatment may be modified, stopped or referred out to the proper practitioner. I reserve the right to withdraw at any time.

Printed Name: _____

Patient/Guardian Signature: _____

Date: _____

Relation of signer to Patient, if signed by person other than Patient: _____

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, I acknowledge that Pursuit Physical Therapy, PLLC has provided me with a copy of its Notice of Privacy Practices, which explains how my protected health information will be handled in various situations as permitted by law.

I understand that I may discuss my concerns and/or any questions I have concerning this Notice of Privacy Practices with the Pursuit Physical Therapy, PLLC representatives.

Patient/Guardian Signature: _____

Date: _____