Beth Shelly PT
1634 Avenue of the Cities
Moline, IL 61265
563-940-2481 cell phone
866-761-7464 fax

***NEW PATIENT INFORMATION:*** Today's Date: _____

Patient's Full Legal Name – please provide a copy of your driver's license or other photo identification
Please complete all sections – print carefully in BLACK ink, Thanks

_____ Sex: Male ___ Female ___
Last First Middle Initial

Date of Birth: _____ Age _____

Address: _____
Street City State Zip

Home Phone: ( )_____ Work Phone: ( ) _____ Place a * on the preferred phone number

Cell Phone ( ) _____ email : _____

Patient Status: (check one) Single: ___ Married: ___ Other: ___
Employment Status: (check one)Employed: ___ Retired: ___ Full-time student: ___ At home mom __

Employer's Name and address _____

Referring Physician_____ Physician Phone number _____

Physician address _____

Reason for seeking Physical Therapy (Diagnosis) _____

***PRIMARY INSURANCE INFORMATION***

Primary insurance company _____ Policy number _____
Please provide a copy of your insurance card

Name of Covered Employee: _____

Employer Providing Primary Insurance: _____

Employer Address: _____
Street City, State, Zip

Relationship to Patient: Self ___ Spouse ___ Parent ____

Insured's name_____ Insured's Birthday _____

Secondary insurance name _____

Secondary insurance policy number _____

Medical history

Please give a brief description of the condition you are coming to physical therapy about.
How did it start? When did it begin?

_____

Is your condition: Getting worse _____ Getting better _____ Staying the same _____

Past treatment or tests for this condition: _____

What are your goals for therapy? _____

Current medications:

| Name of drug | Reason for taking it | Name of drug | Reason for taking it |
|---|---|---|---|
| 1. | | 6. | |
| 2. | | 7. | |
| 3. | | 8. | |
| 4. | | 9. | |
| 5. | | Continue on back if needed | |

Please list all surgeries: _____

Allergies: Latex _____ Rubbing alcohol: _____ Other: _____

Please check all that apply:

| | | | | | |
|---|---|---|---|---|---|
| Heart disease | | Diabetes | | Scoliosis (curve of the spine) | |
| High blood pressure | | Thyroid condition | | Back / neck pain | |
| Pacemaker | | Parkinson's / Alzheimer's | | Broken bones | |
| Stroke | | Cancer | | Fibromyalgia | |
| Lung disease, asthma | | Mental illness | | Difficulty urinating in public | |
| Chronic coughing | | Kidney disease | | Irritable bowel syndrome | |
| TB | | Urinary or fecal leakage | | Others, please list: | |
| Sexual transmitted disease | | Painful intercourse | | | |
| HIV / AIDS | | Sexual abuse | | | |

| | | | | | |
|---|---|---|---|---|---|
| Fever | | Dizziness or faintness | | Sweats | |
| Nausea and vomiting | | Fatigue | | Night pain | |
| Diarrhea | | Weight loss | | | |

Social history

Do you live: Alone _____ With a spouse _____ With others _____
Number of children living with you: _____ Ages _____
Do exercise on a regular basis? What type? _____
Amount of stress(circle one): At home low medium high
At work low medium high
Do you feel safe in your home? _____
Please list any person you would allow information to be shared with (spouse, son / daughter, friend)

Is there any other history you would like to tell me about?

Patient signature: _____ Date: _____

Privacy Act: I authorize Beth Shelly PT to release medical or other information necessary to provide my treatment and process the claim. I understand this information will not be shared unnecessarily and that my personal information is protected under the Privacy act which this office abides by. A copy of office HIPPA policy is available on line or a printed copy will be provided on request. Please ask Beth if a copy is needed.

Patient Initials: _____

Consent to treat: I consent to physical therapy services at Beth Shelly PT. 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: Your success in PT is dependent on regular attendance in therapy. Currently there is a 4 week wait for new patients to start therapy. And I often have a waiting list of patients needing therapy. Please provide 24 hour notice if you are unable to attend. This gives me time to call those on the cancelation list. Failed appointments or those cancelled after 24 hours will be charged a **$50 cancellation fee**. Repeated failures to attend will result in re-evaluation of your need for therapy. Emergencies or weather cancellations will not be charged the cancellation fee. Please help me to provide the best care possible for you and others.

Patient Initials: _____

Statement of Understanding - Notice of Rights for Secure Communication and Waiver of Those Rights

Federal law requires that this practice use secure/encrypted methods when texting or e-mailing patients. At this time, Beth Shelly PT does not offer a secure/encrypted method to communicate electronically with patients. However, I take patient confidentiality and legal compliance *very seriously*.

- My business phone is a cell phone. This also serves as my home phone.
- I am the only person using the phone, I have no secretary. Occasional you may receive a call from the billing company or my assistant, the phone will always be answered by me.
- I will not be able to answer the phone if I am working with a patient. Please leave a message with your name and phone number.
- When texting, also please make sure to include your name.
- Email is also fine, make sure your full name is included.
- At this time my phone and my email are not secure or encrypted.
- I will make every effort to respond to text, phone messages, and emails within 4 hours during the work day or during the morning of the next business day. Please contact me again if I have not responded in 2 days.

These communications may or may not include private information (such as name, health condition, diagnosis, or billing/financial information). I understand the risks inherent in using unsecured/unencrypted communications. I acknowledge that I may change my preference below at any time by notifying the practice in writing.

Initial only those that apply Please place * on the preferred method of communication

I authorize this practice to contact me via unsecured text _____

I authorize this practice to contact me unencrypted email. _____

Please contact me only by phone _____

Patient signature: _____ Date: _____