PhysioPoint
THERAPY & WELLNESS

1841 East Summit Street
Crown Point, IN 46307

219-801-7777

Acknowledgement of Receipt of Notice of Privacy Practices
HIPAA

By my signature below, I acknowledge the following:(check which applies)

☐ I have received PhysioPoint Therapy and Wellness's Notice of Privacy Practices

OR

☐ I have been offered and declined to receive the PhysioPoint Therapy and Wellness's Notice of Privacy Practices.

☐ I would like the following people to have access to my medical records at PhysioPoint Therapy.

____

____

____

Signed:______________________________________

Patient Printed Name:____Date:_______

Relationship to patient if not signed by patient: ______________________________________

GENERAL CONDITIONS FOR PARTICIPATION

Please check each item and sign below:

☐ **CANCELLATION POLICY** Please give us a **PHONE CALL** AT LEAST 24 hours prior to your scheduled visit if you need to cancel an appointment so that someone else can take your spot. Late cancellation or not showing for your scheduled visit will result in a **$50.00 CANCELLATION FEE**.
Emails, Texts or Website communications are NOT acceptable. Please call 219-801-7777.

☐ **AUTHORIZATION FOR THERAPY SERVICES** I understand that I will be informed of the procedure and/or treatments considered necessary for the client whose name appears below and that the treatment and procedures will be performed by a licensed physical therapist and/or associate. I hereby authorize such treatment and procedures.

☐ **INSURANCE VERIFICATION COURTESY** We will verify your insurance benefits as a courtesy, however it is not a guarantee of payment. Ultimately it is your obligation to know your benefits. You will be responsible for charges that your insurance does not pay.

☐ **PARENTAL PERMISSION (If applicable)** I give PhysioPoint Therapy & Wellness permission to treat my child who is under the age of 18 without my presence.

______________________________ ______________________________ ______

Sign Patient or Representative **Print** Patient or Representative **Date**

Please answer YES or NO:

- Are you currently receiving **home health?** ☐ Yes ☐ No
- Is there a **lawsuit** or **lawyer** involved with your condition? ☐ Yes ☐ No
  (*We do not accept any 3rd party payments)

Important Details:

For better treatment outcomes, we ask that **only** the client attend follow-up sessions. We encourage family to accompany the first visit if that is desired. Please wear comfortable clothing to your appointment and shorts if you are coming in with knee pain.

Wellness Goals:

☐ Improved Sleep ☐ Weight Loss ☐ Sports Performance ☐ Running Gait Analysis

Your Medical History

How can we help you? ____

____

Describe your symptoms: (check box(s) that applies)

□ Burning	□ Sharp	□ Worse in AM
□ Dull/Achy	□ Throbbing	□ Worse in PM
□ Shooting	□ Wakes me up	□ Numbness/Tingling
□ Constant	□ Intermittent	Other: ____________

What makes your symptoms worse? (check box(s) that applies)

□ Sitting	□ Up Stairs	□ Lying Down
□ Standing	□ Down Stairs	□ Cough/Sneeze
□ Walking	□ Bending	□ Sleeping
□ Sit to Stand	□ Voiding	Other: _____________

What makes your symptoms better? (check box(s) that applies)

□ Bending	□ Standing	□ AM	□ Heat
□ Sitting	□ Walking	□ PM	□ Ice
□ Turning	□ Lying	□ As the day progresses	□ Medication
□ Rising	□ When Still	□ On the move	Other:_______

Conditions:

□ Allergies	□ Current Infection	□ Fracture	□ Osteoarthritis
□ Asthma	□ Diabetes Type I	□ Gastrointestinal	□ Osteoporosis
□ Cancer	□ Diabetes Type II	□ High Blood Pressure	□ Psychological
□ Car Accident	□ Dizziness/Vertigo	□ Immunosuppression	□ Skin
□ Cardiovascular Disease	□ Fibromyalgia	□ Lung	□ Thyroid
□ Rhuematologic			

Any other conditions? ____

____

Past Surgeries? ____

____

Any of the following performed? □ MRI □ X-ray □ Diagnostic Labs

If so, what were the results? ____

Are you taking any medications, vitamins, supplements, etc? (bring list if you would like)

____

____

____

Gender: □ Male □ Female Height: _______ft _______in Weight: ________lbs.

Date of next doctor visit ____________

How many times have you fallen? ________ Date of last fall: _________

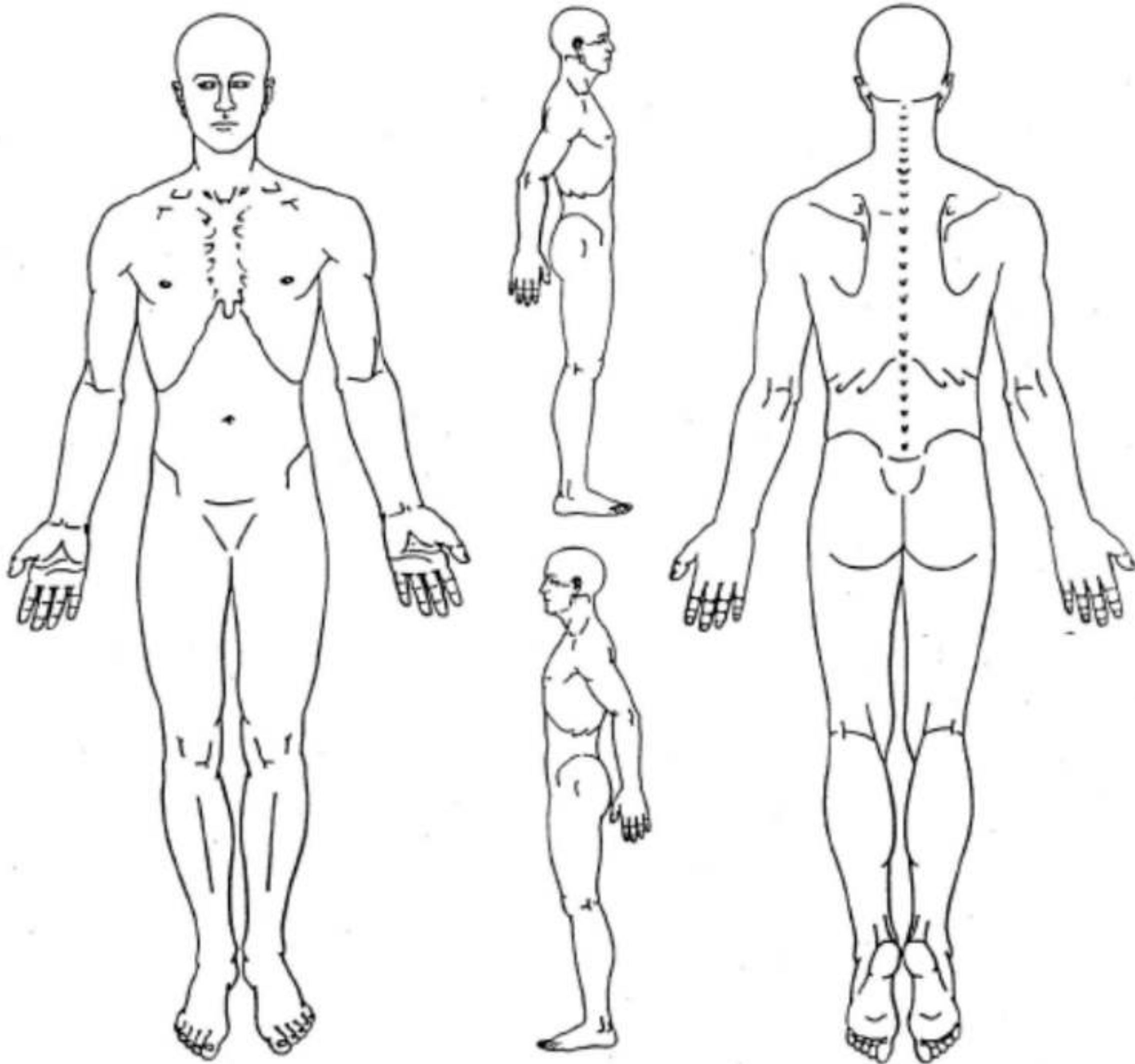
Have you ever been injured in a fall? □ Yes □ No

Current Complaints

On the diagram below mark areas of pain, numbness, or tingling and specify which sensation is present. (Painful, Numbness, Tingling)

Location on body: __________________ Sensation:__________________
Location on body: __________________ Sensation: __________________
Location on body: __________________ Sensation: __________________
Location on body: __________________ Sensation: __________________
Location on body: __________________ Sensation: __________________
Location on body: __________________ Sensation: __________________

Additional comments: ____
____
____



Within the last week, rate your pain from 0 to 10 in the following scenarios (0 = no pain, 10 = worst pain)

At its worst:_____________ Currently:_____________ At its best:_____________