Physical Therapy & Rehabilitation
601 Texan Trail, Suite 250
Corpus Christi, Texas 78411

Telephone: (361)854-0811 EXT 221
Fax: (361)561-0609
www.southtexasboneandjoint.com

Dear Patient,

South Texas Bone & Joint Physical Therapy and Rehabilitation is dedicated to improving functional outcomes by utilizing innovative, evidence-based treatments to better serve your needs. We are aware of the many options you have for physical therapy, and we would like to reassure you that we will do our best to meet your expectations and reasonable goals. Thank you for giving us an opportunity to help you on your way to wellness.

Your physical therapy treatment plan will be customized for your needs and the period of time needed for improvements will vary on your participation. It is very important that you follow your doctor's recommendations, finish all of your visits, and continue your home exercise program to assure that you reach maximum potential. Some patients may notice an increase in symptoms at the beginning of treatment as their bodies adjust to new movement patterns.
With continued effort, you will begin to notice improvement in symptoms. Please consult with your Physical Therapist or Physical Therapist Assistant if you feel that the therapy is not meeting your expectations, or if you experience an increase in symptoms that becomes intolerable.

We continue to strive to improve our team in any way that may be beneficial to you. Our goal is excellence in patient care, and your feedback is always welcomed.

Sincerely,

South Texas Bone & Joint Physical Therapy & Rehabilitation Team

Patient Demographics

Please complete the following

Full Name:

_____

Sex: _____Date of Birth: _____ SS#: _____-_____-_____

Address: _____

City: _____ State: _____Zip Code: _____

Mobile#: ( ) _____-_____ Home#: ( ) _____-_____

Work#: ( ) _____-_____

Email: _____

Marital Status: Single ◉ Married ○ Divorced ○ Widowed ○

Employer's Name: _____

Occupation:_____

Physician's Name: _____

Emergency Contact: _____

Phone#: ( ) _____-_____

Disclosure and Consent

I hereby authorize South Texas Bone & Joint Physical Therapy & Rehabilitation staff to furnish information to Insurance Carriers concerning my illness and treatment and I hereby assign to the Therapist(s) all payments for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature_____

I understand that South Texas Bone & Joint Physical Therapy and Rehabilitation is an extension of South Texas Bone & Joint. Therefore, The New Patient Consent to the Use and Disclosure of Heath Information for Treatment, Payment, or Healthcare Operations will apply to Physical Therapy department.

Initial _____

I have been notified of other Physical Therapy providers available to me and I am aware that I am able to select a provider of my choice. I choose South Texas Bone & Joint Physical Therapy & Rehabilitation as my Physical Therapy provider.

Initial_____

Physical Therapy Intake Form

Please complete the following

Patient Questionnaire/ History

Reason for your visit today?

_____

Indicate the nature of your pain and symptoms:

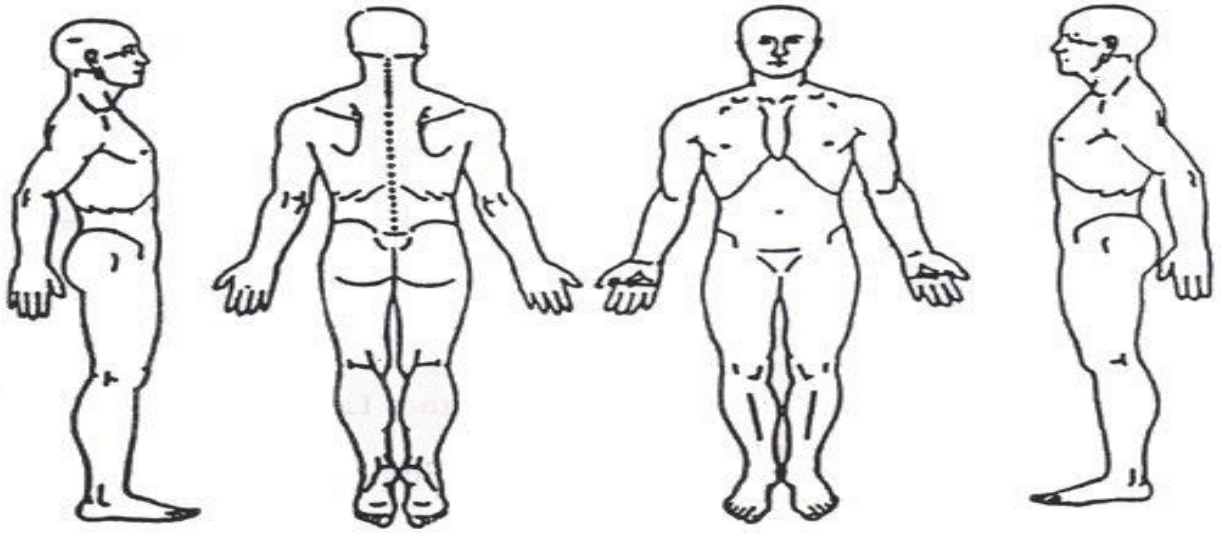
☐ Sharp ☐ Dull ☐ Piercing ☐ Shooting ☐ Aching ☐ Deep ☐ Superficial

☐ Tingling ☐ Numbness ☐ Intermittent ☐ Burning ☐ Stabbing ☐ Throbbing

☐ Other: _____

Symptom Assessment

Please mark areas of concern with an **X** on the pictures below



When and how did this issue begin?_____

What makes your symptoms/pain worse? _____

What makes your symptoms/pain better? _____

Rate your pain on a scale of 0-10 (0 = no pain; 10 = excruciating/worst pain):

Worst it has been_____; Past 2 to 4 weeks_____; Past 24 hours_____;

At this moment_____

Are your symptoms worse in the: __Morning __Afternoon __Evening __Inconsistent

Are your symptoms: _____Improving _____Worse _____Not Changing

Physical Therapy Intake Form

Please complete the following

What treatments have you tried for this issue? _____

Have you had Physical Therapy for this issue previously?_____No;____Yes:_____

Secondary Information: Please check all that are appropriate

What changes have you noticed since your symptoms began? Please describe.

☐ Work
☐ Difficulty Sleeping or staying asleep
☐ Dressing
☐ Bathing
☐ Toileting
☐ Household Chores
☐ Driving
☐ Recreation
☐ Appetite
☐ Have you noticed any changes in weight loss or gain without trying

Diagnostics: Have you had any of the following?

Check the following	Date	Location	Result
☐ X-Ray ☐ MRI ☐ CT Scan ☐ Other			

Medication: Please list all medications currently taking

Prescriptions (you may bring separate list if convenient):

Physical Therapy Intake Form

Please complete the following

Supplements/ Vitamins:
Over the Counter's (examples not limited to: Aspirin, Tylenol, etc):

Past Medical History: Please check all appropriate past or current medical issues

☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Angina ☐ Stroke ☐ Pacemaker ☐ Epilepsy or Seizures ☐ Metal Implants	☐ Osteoporosis ☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Headaches ☐ Infections ☐ Traumatic Injury ☐ Allergies: (List)	☐ Change in Bowel or Bladder Function ☐ Breathing Difficulties ☐ Asthma ☐ COPD or Emphysema	Other: ☐ Bleeding ☐ Circulatory ☐ Intestinal ☐ Thyroid ☐ Liver ☐ Kidney ☐ Gallbladder ☐ Sexual Discomfort
Currently Pregnant?:	Difficult Pregnancy (Brief Explanation)		
Do You Have Any Other Health Issues Or Concerns Not Listed Above?			
Is There Anything Your Doctor Has Told You **NOT** To Do?			

Surgical History

Surgery	***Date***	***Complications?***

Falls and Balance History: Please check all appropriate and describe

Please list how often, how long, and specific location/positions
☐ Falls? How many in the past 6 months?
☐ Changes in Balance or Walking
☐ Dizziness

Physical Therapy Intake Form

Please complete the following

☐ Vertigo
☐ Visual Changes

Social History

Are you presently working?_____Work Status:_____

Restrictions: _____

Physical/Emotional demands of present occupation?
(High, moderate, minimal):

_____

How Would You Describe Your Overall Wellness:
_____Good,_____Fair,_____Poor.

How Would You Describe Your Overall Activity Level:_____Sedentary,_____Light,
_____Moderate,_____Heavy,_____Very Heavy.

Activities and Exercise (Type, Frequency, Duration)

_____

Use of Tobacco_____; How Often_____. Use of Alcohol_____; How Often_____

What is your favorite past time or activity?_____

Anything else you would like your Therapy staff to know about you?_____

_____

Physical Therapy Intake Form

Please complete the following

Goals of Physical Therapy

What are your goals as a result of attending Physical Therapy?
Please include: type of activity, time, level, etc.

1. _____

2. _____

3. _____

4. _____

5. _____

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Release of Medical Records and Information

I_____understand, that for my protection, all medical records requests must be made in writing.

I authorize the following individuals to obtain a copy of my medical records and/or any medical informationn.

Name:	Relationship:	Phone #:

Printed Name_____

Signature _____

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No Show Policy

An appointment has been scheduled for you at the South Texas Bone & Joint Physical Therapy & Rehabilitation Center. We understand that life can be busy and unpredictable and situations may arise where you will not be able to keep your appointment. However, we expect that any patient scheduled for an appointment will contact the office ahead of time to reschedule should they not be able to keep their appointment. If you fail to show without contacting the Office with at least 24-hour notice you will be charged a $25.00 no show fee before being able to reschedule for a new appointment.

Sincerely,

South Texas Bone & Joint Physical Therapy & Rehabilitation Team

Printed Name_____

Signature _____