Pinnacle
HEALTH CONCEPTS
A physical therapy company

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PATIENT DEMOGRAPHICS

Last Name:_____ First Name:_____ MI:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security: _____ Gender: _____ Date of Birth: _____ Age:_____

Marital Status: _____ Student/Employment Status: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Would you like to receive appointment reminders via text or email: _____

Spouse Name: _____ Phone Number: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Insurance: _____ ID Number: _____

Secondary Insurance: _____ ID Number: _____

Responsible Party: _____ Phone Number: _____

How did you hear about us: _____ Date of Onset/Injury: _____

Have you received IN/OUT patient Physical Therapy or any other Therapy services this calendar year: Yes No

If yes, describe services: _____

Have you received any Chiropractic Care this calendar year: Yes No If yes, number of visits: _____

MEDICARE PATIENTS* Have you received Home Health Care this calendar year: Yes No
This includes PT, OT, ST, home health aide or nursing care.

If yes, what is the name of the home health agency: _____

If yes, what is the Discharge date: _____ (please supply copy of discharge report)

MEDICAL HISTORY

***Please circle yes or no*:**

Allergies	YES	NO	Dizzy Spells	YES	NO	MRSA	YES	NO
Anemia	YES	NO	Emphysema/Bronchitis	YES	NO	Multiple Sclerosis	YES	NO
Anxiety	YES	NO	Fibromyalgia	YES	NO	Muscular Disease	YES	NO
Arthritis	YES	NO	Fractures	YES	NO	Osteoporosis	YES	NO
Asthma	YES	NO	Gallbladder Problems	YES	NO	Parkinson's	YES	NO
Autoimmune Disorder	YES	NO	Headaches	YES	NO	Rheumatoid Arthritis	YES	NO
Cancer	YES	NO	Hearing Impairment	YES	NO	Seizures	YES	NO
Cardia Conditions	YES	NO	Hepatitis	YES	NO	Smoking	YES	NO
Cardiac Pacemaker	YES	NO	High/Low Blood Pressure	YES	NO	Speech Problems	YES	NO
Chemical Dependency	YES	NO	High Cholesterol	YES	NO	Strokes	YES	NO
Circulation Problems	YES	NO	HIV/AIDS	YES	NO	Thyroid Disease	YES	NO
COVID-19	YES	NO	Incontinence	YES	NO	Tuberculosis	YES	NO
Currently Pregnant	YES	NO	Kidney Problems	YES	NO	COVID-19 Vaccination	YES	NO
Depression	YES	NO	Metal Implants	YES	NO	Vision Problems	YES	NO
Diabetes	YES	NO						

Describe any other conditions, precautions or any of the above that you answered yes: _____

_____

_____

_____

_____

FALL HISTORY

Is this injury a result of a fall in the past year: YES NO Date of Fall: _____

Have you had two or more falls in the last year: YES NO Date of Falls: _____

SURGICAL HISTORY

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

CURRENT SYMPTOMS

***Please circle yes or no*:**

Fever/chills/sweats	YES	NO	Poor Balance	YES	NO	Unexplained weight loss	YES	NO
Changes in appetite	YES	NO	Difficulty swallowing	YES	NO	Numbness or tingling	YES	NO
Depression	YES	NO	Dizziness	YES	NO	Shortness of breath	YES	NO
Headaches	YES	NO	Nausea / vomiting	YES	NO	Increased pain at night	YES	NO
Change in bowel or Bladder function	YES	NO						

During the past month, have you often been bothered by feeling down, depressed, or hopeless? YES NO

During the past month, have you been bothered by little interest or pleasure in doing things? YES NO

Is this something with which you would like help? YES – today YES – but not today No – I do not want help

CURRENT MEDICATIONS *(Please complete below or bring in a current list of medications)*

Drug: _____ Dosage: _____ Reason for taking: _____

Drug: _____ Dosage: _____ Reason for taking: _____

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Drug: _____ Dosage: _____ Reason for taking: _____

Drug: _____ Dosage: _____ Reason for taking: _____

I authorize Pinnacle Health Concepts to discuss my health information with the following persons:

1. _____ Relationship: _____

2. _____ Relationship: _____

The above information is correct to the best of my knowledge.

Patient Signature: _____ Date: _____

Parent/Guardian (if patient is a minor): _____ Date: _____

PATIENT CONSENT TO TREAT

I authorize Pinnacle Health Concepts P.T. to render appropriate treatment to me. I understand appropriate personnel will provide this treatment and that I have the right to refuse. _____

I authorize Pinnacle Health Concepts P.T. to obtain or provide emergency care if conditions warrant it during a treatment session and I am unable to give consent (CPR or emergency care). _____

A PATIENT HAS THE RIGHT TO:

1. Be informed of the nature of their condition, the proposed treatment and alternatives, and the expected results/risks of the proposed treatment to the best of their knowledge.

2. Be fully informed about the care and treatment to be furnished and participate in the planning and changing of care and treatment. This includes refusal of all or part of the proposed treatment after being informed of expected consequences of an activity.

3. Voice grievances regarding care and treatment that is or is not furnished.

4. Be informed of any experimental treatment and not receive such treatment.

*****PHYSICAL THERAPY HAS THE RIGHT TO EXPECT THE PATIENT TO:**

1. Provide complete and accurate medical history and other necessary information in a timely fashion. This includes necessary billing information.

2. Read and ask questions about all forms and documents that are requested to be signed.

3. Participate in the development and review of the plan of treatment.

4. Adhere to the treatment plan developed by the physical therapist including home exercises.

5. Take an active role in identifying specific activities necessary for care.

6. Be present and on time for scheduled appointments.

7. Report undue stress and discomfort that may be elicited during a treatment in a timely fashion.

PATIENT INFORMATION ACKNOWLEDGEMENT

I have read and fully understand Pinnacle Health Concept's Notice of Information Practices. I understand that Pinnacle Health Concepts P.T. may use my personal information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to payment or treatment. I have been given an opportunity to obtain a copy of Pinnacle Health Concept's Notice of Privacy Practices should I ask for it.

Patient Signature: _____ Date: _____

Parent/Guardian (if patient is a minor): _____ Date: _____

OUR FINANCIAL POLICY

Please initial following each statement to authorize.

Insurance is a contract between the patient or guarantor and the insurance company. Pinnacle Health Concepts Physical Therapy only bills insurance as a courtesy to the patient. I am financially responsible to Pinnacle Health Concepts P.T. for services rendered. _____

I fully understand that Pinnacle Health Concepts P.T. may not accept my insurance fees as payment in full. This would lead to my receiving a bill for deductibles, co-payments, co-insurance and non-covered items. I agree to pay for any such balance. _____

Pinnacle Health Concepts P.T. accepts payment in the form of cash, check, or charge. If I pay via credit card, Pinnacle Health Concepts P.T. can keep my card on file unless told otherwise. This card will be used for all applicable co-pays, co-insurance, and deductible payments. _____

I understand that it is my responsibility to obtain all necessary referrals from my doctor or Primary Care Physician as required by my insurance company. In the event that services are rendered and later denied by my insurance company(s) for lack of referral/pre-authorization, I understand that it will be my responsibility to pay Pinnacle Health Concepts P.T. for services rendered. _____

Unless appointments are cancelled at least 24 hours in advance, our policy is to charge $75.00 for missed appointments. This charge is not covered by insurance and is my responsibility to pay. _____

ASSIGNMENT OF BENEFITS

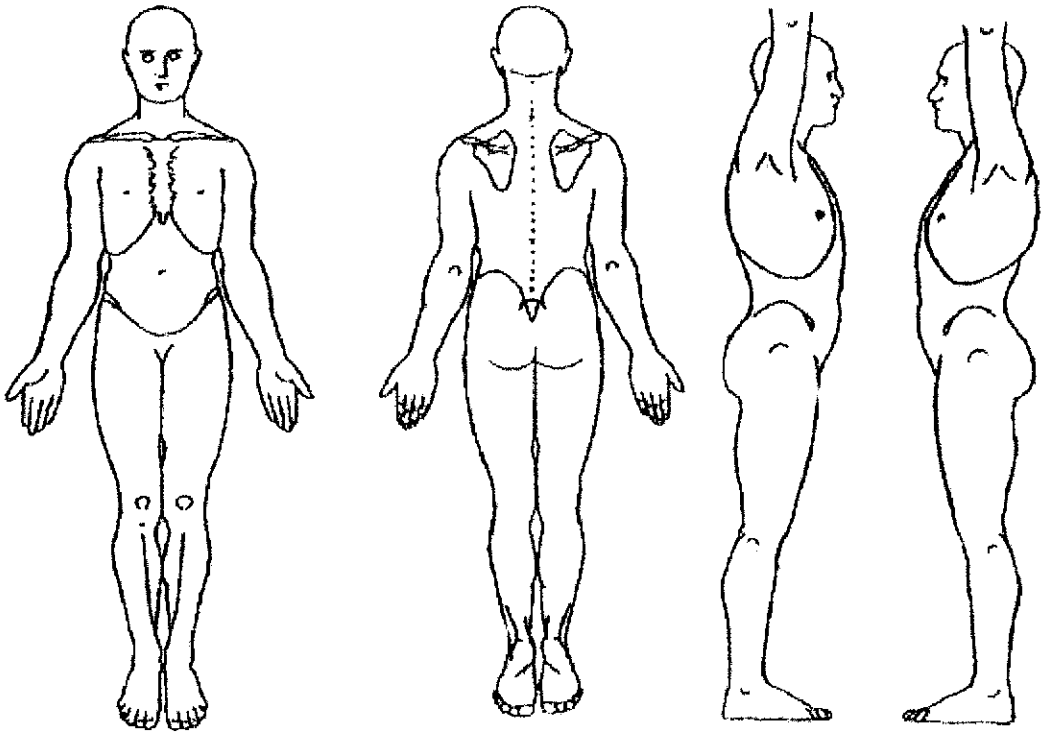
I have read the Financial Policy. I understand and agree to this policy. I hereby authorize my insurance company to pay all benefits directly to: Pinnacle Health Concepts.

Patient Signature:_____ Date:_____

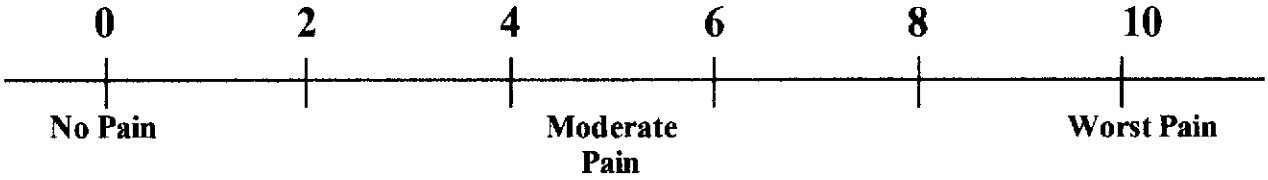
Parent/Guardian, if patient is a minor:_____

PLEASE LIKE AND FOLLOW US ON FACEBOOK AND INSTAGRAM!!!

PAIN LOCATION BODY CHART



PAIN INTENSITY SCALE



- Please mark a number on the pain intensity scale that best describes your pain at the present time.
- Draw the location of you pain on the body chart above
- If you have any other symptoms, such as tingling or numbness, draw these as a dotted line.

Please describe the details of your injury, including the date of injury and any treatment on the injury:

Name:_____ **Date:**_____