Resilient
Physical Therapy and Wellness

Thank you for choosing Resilient Physical Therapy and Wellness, LLC! Please fill out the following forms completely and to the best of your knowledge. This information will help us to better serve you. All information will remain private and confidential.

Patient Name: _____ DOB: _____ Sex: ☐ Male ☐ Female
Address: _____
City: _____ State: _____ Zip: _____
Phone: Home: _____
Cell: _____
Work: _____
Email: _____
Preferred Method of Contact: _____

Relationship Status:
☐ Single
☐ Married
☐ Separated
☐ Widowed
☐ Partner

Referring Physician (if applicable): _____ Phone: _____
Address: _____
Primary Physician: _____ Phone: _____
Address: _____

Insurance Carriers:
Primary: _____ Phone: _____
Secondary: _____ Phone: _____

Emergency Contact (Please provide a reliable local contact)
Name: _____ Relationship: _____
Phone: Home: _____
Cell: _____

Consent to Treat

I voluntarily authorize Resilient Physical Therapy and Wellness, LLC to perform outpatient diagnostic evaluation(s) and/or procedure(s) and to administer such outpatient therapy that is necessary. I understand that outpatient therapy is not an exact science and no guarantee has been made as to the result of any treatment or care administered.

Patient Signature_____

I have completed the above information to the best of my knowledge.

_____ _____
Patient Signature Date

Resilient Physical Therapy and Wellness, LLC
Phone: 617-356-8221
Email: sarah@resilientphysicaltherapy.com

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MEDICAL HISTORY FORM

Please complete the following to the best of your ability.

1. Name **DOB**

_____ __/__/__

Last First MI

2. Employment

- ☐ Full Time
- ☐ Part Time
- ☐ Not Currently Working

Hours spent sitting at desk each day: _____

Is heavy lifting required? If yes, describe_____

_____

3. Home Environment

With whom do you live?

- ☐ Live alone
- ☐ With spouse
- ☐ With family
- ☐ With friends

Does your home have any of the following?

- ☐ Stairs - How many? _____
- ☐ Ramps
- ☐ Elevator

4. Current Injury

Briefly describe your current injury:_____

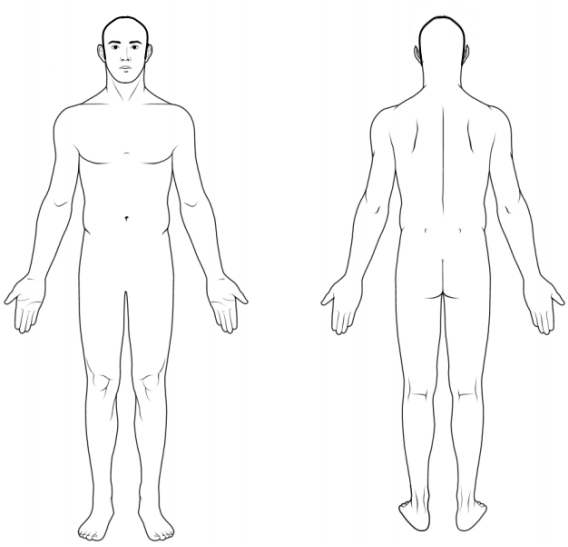
_____

Date of onset: ___/___/___

List any diagnositic tests done for this condition (X-ray, MRI, etc) _____

List any other treatment you have had for this condition_____

Please circle where your pain is located:

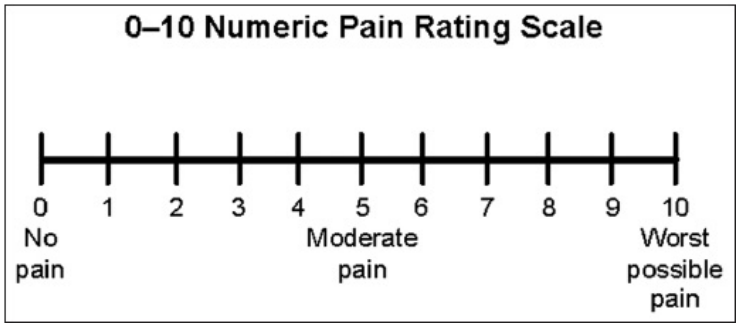


Pain Intensity (0-10 Scale)

Worst: _____

Best: _____

Current: _____



5. Medical History

Please list your current medications and dosages (or provide copy of detailed list):

_____

Do you now have or have you ever had any of the following?

Yes	No	Condition	Yes	No	Condition
		Pacemaker			Arthritis
		Metal Implants			Osteopenia
		High Blood Pressue			Osteoporosis
		Diabetes			Cancer/Tumor
		Heart Disease			Recent Weight Loss or Gain
		Heart Attack			Current Infections
		Vascular Disease			Tuberculosis
		Stroke			Hepatitis
		Asthma			Skin Conditions (describe below)
		Shortness of Breath			Headaches
		Chronic Cough			Head Injury/Concussion
		Fainting Spells			Hernia
		Deep Vein Thrombosis (DVT)			Bowel or Bladder Problems
		Anemia			Thyroid Problems
		Fracture (describe below)			Substance Abuse
		Previous Surgeries			Other

Please describe all yes answers briefly below and approximate dates:

_____

_____

_____

If there are any medical conditions not listed above, please describe them here.

_____

_____

Do you have any allergies? List them here. _____

Women only: Date of last menstrual cycle: _____

Are you currently pregnant? ☐ Yes ☐ No If yes, due date: ____/_____/_____

Past pregnancies: #_____ C-section? _____

6. Exercise Routine

If you have a regular exercise routine, please describe it here.

Frequency: _____ days/week

Duration: _____min/day

Typical routine (running, machines, etc): _____

Are you training for an upcoming event, such as a road race?_____

Date of event: _____

If you are seeing another healthcare provider for this condition, may we discuss your current care with them? ☐ Yes ☐ No

I have completed the above information to the best of my knowledge.

_____ ___/___/___

Patient Signature Date

PAYMENT POLICY

I understand that payment is expected on the day of each session or paid in advance. I am responsible for all charges, regardless of insurance coverage. I understand that **Resilient Physical Therapy and Wellness, LLC** is not a Medicaid or Medicare Provider and, therefore, cannot submit payment for reimbursement. I understand that prompt payment is expected for services and I agree to pay for services as expected.

Patient/ Guardian Signature_____Date_____

CANCELLATIONS AND MISSED APPOINTMENT POLICY

When you schedule an appointment with our practice, that time is reserved for you. When you miss the appointment without calling to cancel within a reasonable amount of time, your practitioner does not have the opportunity to offer that time to someone else in need of services. Missed appointments can also interfere with your progress in treatment. It is our policy that patients are responsible for all appointments that they have scheduled. Patients who choose not to attend, or those who call to cancel their appointments at the last minute, are still responsible for these appointment times and the cancellation fee.

The following policy applies to all appointments:

1) **24 HOURS NOTICE IS REQUIRED TO CANCEL EACH APPOINTMENT YOU HAVE SCHEDULED**

2) **CANCELLATIONS ARE ACCEPTED IN THE FOLLOWING FORMS <u>ONLY</u>:**

- Email: sarah@resilientphysicaltherapy.com
- Phone call/Voicemail: 617-356-8221
- Canceling via Full Slate if booked with online scheduling.

3) **LATE CANCELLATIONS OR MISSED VISITS WILL RESULT IN A $50 FEE.**

Fees for missed appointments and/or late cancellations are expected at or before the patient's next scheduled appointment. **Insurance does not cover these fees.**

Any patient who misses more than three appointments without sufficient notice is subject to review and may be required to pay in advance for scheduled sessions. They may also be discharged from physical therapy since poor attendance significantly limits rehabilitation progress and potential.

Note: If the therapist is running late, the client will receive their full treatment time. When the client is late for the session, the client incurs the loss of time and payment for the full session is expected.

We thank you for your full cooperation and understanding of this policy.

Patient/Guardian Signature _____ Date_____