



**I. Medical History:** Have you ever been diagnosed with or do you have any of the following conditions?

(Check all that apply)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Cancer                                | <input type="checkbox"/> None of these apply to me         | <input type="checkbox"/> Epilepsy                            |
| <input type="checkbox"/> Heart problems                        | <input type="checkbox"/> Tuberculosis                      | <input type="checkbox"/> Hepatitis                           |
| <input type="checkbox"/> Chest pain/angina                     | <input type="checkbox"/> Sexually transmitted disease/ HIV | <input type="checkbox"/> Ulcers                              |
| <input type="checkbox"/> Circulation problems                  | <input type="checkbox"/> Rheumatoid Arthritis              | <input type="checkbox"/> Liver problems                      |
| <input type="checkbox"/> Blood clots                           | <input type="checkbox"/> Arthritis                         | <input type="checkbox"/> Allergies/asthma                    |
| <input type="checkbox"/> Stroke                                | <input type="checkbox"/> Bladder/urinary tract infection   | <input type="checkbox"/> Pacemaker                           |
| <input type="checkbox"/> Anemia                                | <input type="checkbox"/> Kidney problems/infection         | <input type="checkbox"/> Blood thinners                      |
| <input type="checkbox"/> Chemical dependency (i.e. alcoholism) | <input type="checkbox"/> Cholesterol high/low              | <input type="checkbox"/> Fibromyalgia                        |
| <input type="checkbox"/> Depression                            | <input type="checkbox"/> Thyroid problems                  | <input type="checkbox"/> Broken bones                        |
| <input type="checkbox"/> Anxiety                               | <input type="checkbox"/> Diabetes                          | <input type="checkbox"/> Recent infection /illness (explain) |
| <input type="checkbox"/> Lung problems                         | <input type="checkbox"/> Osteoporosis                      | <input type="checkbox"/> Other                               |
|  | <input type="checkbox"/> Multiple Sclerosis                |  |

Past surgical history (list & date): \_\_\_\_\_

Significant family medical history: \_\_\_\_\_

During the past month have you been feeling down, depressed, or hopeless? Yes No

During the past month have you been bothered by having little interest or pleasure in doing things? Yes No

Is depression or anxiety something you would like help with today? Yes Yes, but not today No

Do you ever feel unsafe at home, or has anyone tried to hit or injure you in any way? Yes No

If you are over 65, how many falls have you had in the last 6 months? \_\_\_\_\_

Are you taking any medications? No Yes If yes, please list, or I've attached my own list to this paperwork:

Medication name:	Amount:	Dose:
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Tobacco use:** Yes No **Alcohol use:** Yes No **Vitamin D supplement:** Yes No

**II. Current Symptoms** Problem(s) you are here for: \_\_\_\_\_

What date (roughly) did your symptoms start? \_\_\_\_\_

What do you think started your symptoms? \_\_\_\_\_

Are your symptoms related to a work injury? Yes No Or a motor vehicle accident? Yes No

Symptoms are currently:  Getting better  Getting worse  Staying about the same

Come and go  Constant  Constant, but change with activity

Treatments so far for this problem (injections, chiropractic, etc.): \_\_\_\_\_

Have you had an X-ray, MRI, or other imaging for this problem? Yes No

If yes, please list, including date: \_\_\_\_\_

Have you ever had this problem before? Yes No

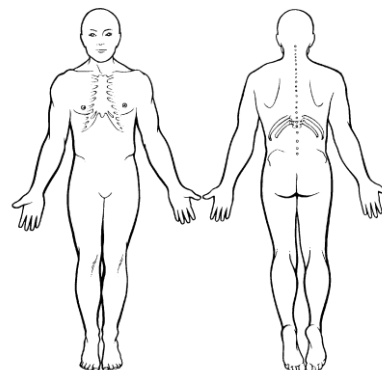
If yes, when and how it was treated: \_\_\_\_\_

What is your personal goal for therapy? \_\_\_\_\_

**Body chart:** Please mark **all** areas where you feel symptoms on the chart to the right

What makes your symptoms **better**? \_\_\_\_\_

What make your symptoms **worse**? \_\_\_\_\_



On the scale below, please mark the number which best represents the severity of your pain over the past 24 hours:



0

1

2

3

4

5

6

7

8

9

10



No Pain

Worst pain imaginable

SINCE YOUR SYMPTOMS BEGAN, have you noticed any of the following? (Check all that apply)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Skin changes                                | <input type="checkbox"/> Numbness or tingling  | <input type="checkbox"/> Fever/chills/sweats               |
| <input type="checkbox"/> Fatigue                                     | <input type="checkbox"/> Falls                 | <input type="checkbox"/> Nausea/vomiting                   |
| <input type="checkbox"/> Generalized muscle weakness                 | <input type="checkbox"/> Shortness of breath   | <input type="checkbox"/> Abdominal pain                    |
| <input type="checkbox"/> Pain at night                               | <input type="checkbox"/> Heartburn/indigestion | <input type="checkbox"/> Fainting                          |
| <input type="checkbox"/> Leg swelling                                | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Cough                             |
| <input type="checkbox"/> Weight loss/gain                            | <input type="checkbox"/> Headaches             | <input type="checkbox"/> Chest pain especially with sweats |
| <input type="checkbox"/> Difficulty maintaining balance when walking | <input type="checkbox"/> Changes in appetite   | <input type="checkbox"/> Other _____                       |
| <input type="checkbox"/> Changes in bowel or bladder function        | <input type="checkbox"/> Heart palpitations    | <input type="checkbox"/> <b>None of these apply to me</b>  |
| <input type="checkbox"/> Changes in cognition                        |  |  |

Describe your usual exercise routine: \_\_\_\_\_

How are you able to sleep at night? Fine Moderate difficulty Only with medication

**III. How did you hear about our clinic?**

- My doctor's office  I am referring myself for PT  Family/friend/colleague recommended  My insurance company said you were in my network  I did a search on the internet  My trainer  Other \_\_\_\_\_

Please tell us who we can thank for sending you our way: \_\_\_\_\_

**Consent to Treatment**

1. I have presented myself to this facility for therapy treatments and consent to the care (history, physical examination, treatment, etc.) that will be provided by my therapist.

2. I realize I have the right to refuse any treatments or procedures to the extent permitted by law. I acknowledge that the delivery of health care does not guarantee results of any treatments at this facility. I understand that information from any medical record(s) kept by this facility may be used for educational, administrative, and/or facility approved purposes when my personal identity will not be revealed.

3. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service. I am responsible for any services not covered by this authorization. I have read and fully understand the Patient Financial Responsibilities Form.

4. Worker's Compensation - I hereby authorize Capitol Physical Therapy to receive my records related to my work injury.

**Photo/Video Authorization**

I grant to Capitol Physical Therapy and its affiliated entities, and its representatives and employees (collectively the "Company") the right to take photographs and/or videos of me in connection with my participation in physical therapy services. I authorize the Company, to copyright, use and publish the same in print and/or electronically. I agree that the Company may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content and waive any right to compensation therefore. I understand that I may revoke this authorization but only in writing delivered to the clinic office manager. I understand that if I choose to revoke this Authorization, the revocation will not be effective for any uses and/or disclosures of my protected health information that have already been made in reliance on this Authorization.

Agree or  Decline

**Notice of Privacy Practices**

By signing this form, I acknowledge that Capitol Physical Therapy has made its' Privacy Notice available to me, which explains how my health information will be handled

in various situations. I understand that I may discuss my concerns and/or any questions I have concerning this Privacy Notice with Capitol Physical Therapy representatives.

**PT Benefits Provided by Your Insurance Company**

I acknowledge that my physical therapy benefits have been explained to me to my satisfaction. I understand that I am ultimately responsible for any copays, deductible(s), and/or co-insurance. I acknowledge that I should contact a representative of Capitol Physical Therapy if I do not understand my benefits, have questions regarding payment due, or if I am unable to provide payment for my services prior to receiving treatment.

In the unlikely event your account would be turned over to a collection agency you would be responsible for all filing, collection, and legal fees necessary to obtain full recovery of any unpaid balance due CPT. There will also be interest added to invoices with balances over 30 days.

I agree to allow CPT to file my Health Insurance should my worker's compensation, auto, or third party insurance deny the claim, exhaust the benefits, or fail in any way to pay the claim.

**Release of Information**

I authorize the following individuals to receive information regarding my diagnosis, treatment, and billing:

Name:	Relationship:

**Authorization**

I acknowledge, as indicated by my signature below, that I have read and fully understand this consent form. By signing this form, I am acknowledging my understanding of the "Notice of Privacy Practices" and authorizing persons listed on the Information Release to receive my health information.

Print Patient Name:

\_\_\_\_\_

Patient or Guardian Signature:

\_\_\_\_\_

CPT Employee Signature \_\_\_\_\_

Date of Authorization: \_\_\_\_\_



## APPOINTMENT CANCELLATION POLICY

All appointment cancellations must be made by 12:00 a.m., the night before your scheduled appointment. This can be done either in person, on the phone, or by leaving us a voicemail at the number listed below. If you do not cancel your appointment by 12:00 a.m., or if you do not show for your appointment, you will be charged \$25.00 regardless of whether or not you have received reminder(s) from our office.

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Signature

Date

VERONA CLINIC:	608-848-6628
MOUNT HOREB CLINIC:	608-437-0222
SUN PRAIRIE CLINIC:	608-318-1357
WAUNAKEE CLINIC:	608-850-7275
UNIVERSITY AVE CLINIC:	608-467-3537