



# Axis Physical Therapy Inc

Treatment that revolves around the client

Address: 21009 76th Ave West, Edmonds, WA

Phone: (425) 672-2910 Fax: (425) 778-1872

Phone: (425) 245-8548 Fax: (425) 245-8547

Welcome to our office.

Please complete this paperwork to the best of your ability. Feel free to ask any questions.

## Patient Information

First Name: \_\_\_\_\_ M. I. \_\_\_\_\_ Last Name: \_\_\_\_\_

Sex:  Male  Female Birth Date: \_\_\_\_\_ Social Security: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse/Partner Name: \_\_\_\_\_

Parent/Guardian Name (if applicable): \_\_\_\_\_

Street Address: \_\_\_\_\_ Unit: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employment Status:  Full Time  Part Time  Retired  Not Employed Other: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Please list YOUR contact phone numbers in the order in which you wish to be contacted. Checking voicemail and/or text after each number authorizes Axis Physical Therapy to leave confidential voicemails or appointment reminder texts with you, and voicemails with your emergency contacts.

PHONE NUMBER	TYPE OF PHONE	VOICEMAIL OR TEXT?
	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	<input type="checkbox"/> Voicemail <input type="checkbox"/> Text
	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	<input type="checkbox"/> Voicemail <input type="checkbox"/> Text
	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	<input type="checkbox"/> Voicemail <input type="checkbox"/> Text

Axis Physical Therapy may ALSO leave a voice message with:

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Phone Number: \_\_\_\_\_

In the case of an emergency Axis Physical Therapy may contact:

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Please provide an e-mail address to receive any Physiotec exercises:

\_\_\_\_\_ @ \_\_\_\_\_

By signing below you acknowledge your permission for Axis Physical Therapy staff to contact the persons at the phone numbers as you have listed them above.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name if signed on behalf of the patient: \_\_\_\_\_

Relationship of guardian to patient: \_\_\_\_\_



**Care Information**

Referring Practitioner: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

**Workers Compensation and/or Personal Injury Protection:**

Claim Manager's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Injury/Accident: \_\_\_\_\_ Location (State) of Accident: \_\_\_\_\_

Attorney: \_\_\_\_\_ Attorney's Phone: \_\_\_\_\_

Attending Physician on file with L&I: \_\_\_\_\_

**Health Insurance:**

**Primary Insurance Coverage**

Insurance Company: \_\_\_\_\_

ID/Claim Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Type of Insurance:  Commercial  Medicare  PIP  Workers Compensation Other: \_\_\_\_\_

Subscriber's Full Name: \_\_\_\_\_

Subscriber's Birthday: \_\_\_\_\_ Patient's Relationship to Subscriber: \_\_\_\_\_

Is the subscriber address the same as the patients?  Yes  No

**Secondary Insurance Coverage**

Insurance Company: \_\_\_\_\_

ID/Claim Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Type of Insurance:  Commercial  Medicare  PIP  Workers Compensation Other: \_\_\_\_\_

Subscriber's Full Name: \_\_\_\_\_

Subscriber's Birthday: \_\_\_\_\_ Patient's Relationship to Subscriber: \_\_\_\_\_

Is the subscriber address the same as the patients?  Yes  No

**Tertiary Insurance Coverage**

Insurance Company: \_\_\_\_\_

ID/Claim Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Type of Insurance:  Commercial  Medicare  PIP  Workers Compensation Other: \_\_\_\_\_

Subscriber's Full Name: \_\_\_\_\_

Subscriber's Birthday: \_\_\_\_\_ Patient's Relationship to Subscriber: \_\_\_\_\_

Is the subscriber address the same as the patients?  Yes  No

Please sign below indicating that the information provided is true and correct to the best of your knowledge.

Patient/Guardian Signature: \_\_\_\_\_

Print Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_



Current Condition Information

What current condition(s) are you here for today? \_\_\_\_\_

What is the date of onset or most recent exacerbation of the condition? \_\_\_\_\_

Cause of injury: \_\_\_\_\_

What is the most important activity you are here to improve: \_\_\_\_\_

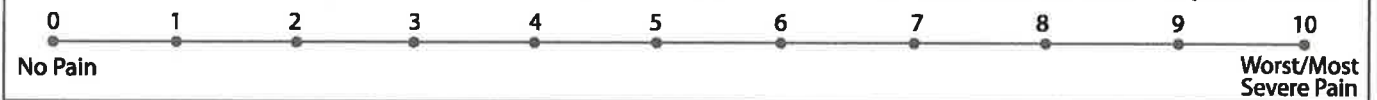
Has the patient seen any other specialist for this condition before? Yes No If yes, what is the name of the practitioner and date of most recent visit? \_\_\_\_\_

Please describe previous treatment received related to this condition: \_\_\_\_\_

Any Imaging? (i.e. MRI, CT, X-Ray) \_\_\_\_\_

Is the patient in pain today? Yes No What is the patient's dominant hand? Left Right

Use the scale below to indicate the intensity of pain, please write in REST and ACTIVITY if pain varies:



What are the frequency of symptoms? \_\_\_\_\_

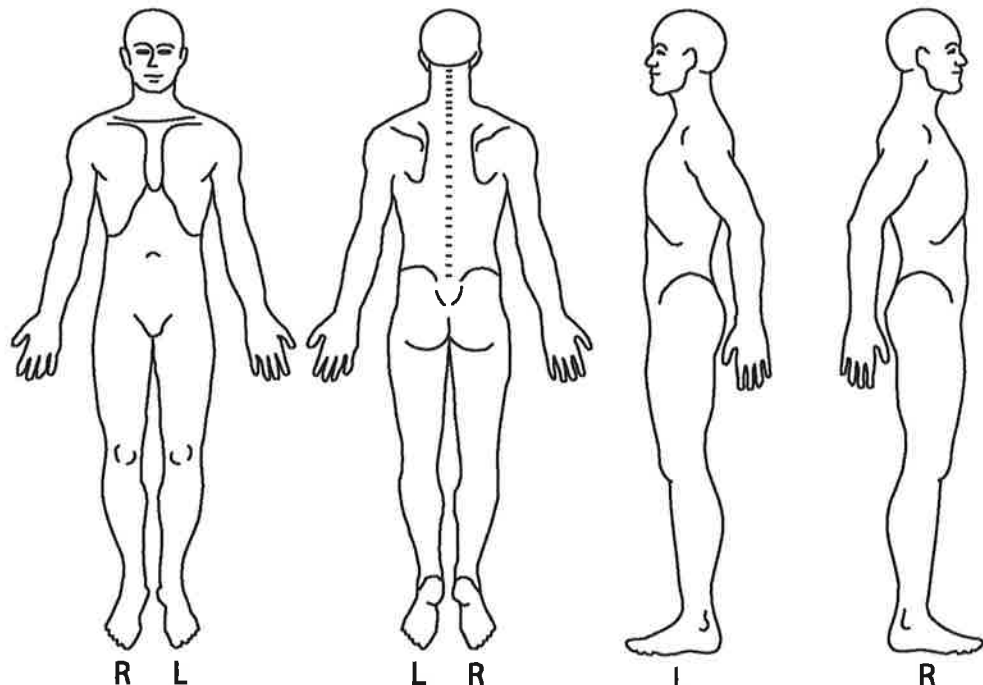
What aggravates the condition? \_\_\_\_\_

What relieves it? \_\_\_\_\_

Please use the diagram to indicate what areas of the patient's body will be treated:

What has the pain affected?

- Mobility
- Sleep
- Exercise
- Relationships
- Work
- Social
- Activity
- Concentration
- Appetite
- Other \_\_\_\_\_



Print Patient Name: \_\_\_\_\_



General Health Information & History

Please check all following therapies the patient has had previously: Physical Aquatic Massage  
If yes, please tell us where and when the patient received therapy: \_\_\_\_\_

Has the patient sustained any injuries related to work or to car accident: Yes No If yes, please describe including dates: \_\_\_\_\_

Does the patient have any other pertinent medical history? \_\_\_\_\_

Did the patient have any childhood injuries? \_\_\_\_\_

Does the patient have any congenital diagnoses? \_\_\_\_\_

Has the patient sustained any sports injuries in the past? \_\_\_\_\_

Any additional health history: \_\_\_\_\_

Date of patient's last physical exam: \_\_\_\_\_

Please use this box to fill out all surgical history:

Surgery	Date	Any residual issues:

If you need more space, use the back of page and please let us know.

Pregnancy Information

Are you pregnant? Yes No Currently Trying \*If No, please skip to Health History.

If yes, how many weeks: \_\_\_\_\_ Due Date: \_\_\_\_\_

Are you having any complications and/or concerns with your pregnancy: \_\_\_\_\_

Any history of complications or miscarriage: \_\_\_\_\_

Print Patient Name: \_\_\_\_\_



General Health Information & History

During the past few months has the patient exhibited any signs of depression? Yes No  
 Has the patient recently lost interest or pleasure in his or her enjoyed activities? Yes No  
 How often does the patient exercise: None 1-2/week 3-4/week 5+/week  
 Types of exercise: \_\_\_\_\_

Please indicate any current habits the patient exhibits and frequency: (i.e. 4 cigarettes/day)  
Smoking: \_\_\_\_\_ Alcohol: \_\_\_\_\_ Coffee/Soda: \_\_\_\_\_ Other: \_\_\_\_\_ : \_\_\_\_\_  
 Work Activity:(Select all that apply.) Sitting Standing Light Labor Heavy Labor \_\_\_\_\_  
 Please indicate patient's stress level: Low Moderate High What causes the stress? \_\_\_\_\_

**FAMILY HISTORY: Check all that apply.**

	PATIENT	FAMILY		PATIENT	FAMILY
Cancer (type): _____	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems/Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis (type): _____	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

**CHECK ANY of the following you experience, particularly if it is new or unusual to you.**

	PATIENT		PATIENT		PATIENT
Fatigue	<input type="checkbox"/>	Loss of Vision	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	Eye Redness	<input type="checkbox"/>	Regular Cough	<input type="checkbox"/>
Nausea/Vomiting	<input type="checkbox"/>	Hearing Problems	<input type="checkbox"/>	Arm/Leg Swelling	<input type="checkbox"/>
Fever/Chills/Sweats	<input type="checkbox"/>	Skin Rash	<input type="checkbox"/>	Heart Racing	<input type="checkbox"/>
Dizziness/Light-headedness	<input type="checkbox"/>	Sleeping Problems	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>
Numbness or Tingling	<input type="checkbox"/>	Sexual Difficulties	<input type="checkbox"/>	Heartburn/Indigestion	<input type="checkbox"/>
Tremors	<input type="checkbox"/>	Joint/Muscle Swelling	<input type="checkbox"/>	Constipation/Diarrhea	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	Blood in Urine/Stool	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	Difficulty Urinating	<input type="checkbox"/>

Please sign below indicating that the information provided is true and correct to the best of your knowledge.

Patient/Guardian Signature: \_\_\_\_\_

Print Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_



Medication Information

Please use this area to provide a list of all medications and supplements the currently used by the patient. If the the patient furnished a separate list, please attach it here. Feel free to use the back of the page for more space.

Medication Name:	Medication Purpose:

Allergy Information

Please use this box to list any and all allergies:

Allergy:	Symptoms (i.e. rash, nasal congestion, constipation)

Print Patient Name: \_\_\_\_\_



## Consent to Treat & Protected Health Information Policy

This patient and/or guardian consent to the use or disclosure of protected health information by Axis Physical Therapy for the purpose of providing treatment, obtaining payment and conducting health care operations. The patient and/or guardian understands that all treatment received from a Physical Therapist, Physical Therapy Assistant and/or Massage Therapist may be conditioned upon consent as evidence by signature on this document.

This patient and/or guardian have the right to request a restriction or revoke consent as to how any and all Protected Health Information (PHI) is used or disclosed, in writing, at any time. PHI refers to individually identifiable health information that is transmitted or maintained in any media. This patient and/or guardian have the right to review the Notice of Privacy Practices prior to signing this document. By signing, this patient and/or guardian certifies that the Notice of Privacy Practices has been provided to the patient and/or guardian. The notice provides the types of uses and disclosures of PHI that may occur in treatment, the rights of the patient and the duties of Axis Physical Therapy with respect to PHI.

Axis Physical Therapy reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. The patient and/or guardian may obtain a revised copy of any such changes at the time of any following appointment, view the document online or request a copy by mail.

### Insurance Payments:

By signing below the patient and/or guardian hereby authorize that insurance payments be paid directly to Axis Physical Therapy. The patient and/or guardian authorize the release of any information required to process insurance claims. Should any payment for services provided to the patient be made out in the patient's name, the patient and/or guardian gives this office limited power of attorney to endorse any such check for deposit. The patient and/or guardian understands that they are financially responsible for any remaining balance.

During any treatment at Axis Physical Therapy any balance accrued due to deductible and/or co-insurance is payable within the month upon receipt of statement. If the financially responsible party is unable to pay the balance within the month and fails to establish a payment plan, treatment may be suspended. Axis Physical Therapy takes all forms of payment and payments may be made in person, over the phone or by mail. When the patient's treatment is concluded, suspended or terminated, all fees for professional services become immediately due within ninety days. If after ninety days there is no formal payment plan, the account balance is turned over for collection action and the patient/guardian will be responsible for all fees related to efforts in collecting an unpaid account balance. The patient and/or guardian acknowledges that there is a \$35 fee for any returned checks. The patient and/or guardian acknowledges that co-payments, not billable to secondary insurance, are due at time of service.

### Cancellation Policy:

24 Hour advanced notice is required to cancel any appointments the patient is unable to attend. Any no-show appointment or appointment cancelled with less than 24 hour notice will be subject to a \$65.00 fee. This fee is not billable to insurance and will be applied to the patient's account balance. If the patient misses three scheduled appointments without appropriate notification, Axis Physical Therapy reserves the right to terminate all future care.

### Cashrate Patients:

Cash rate payments are due at the time of service. If the financially responsible party is unable to make cash rate payments at the time of treatment, it is that party's responsibility to cancel any appointments with at least 24 hours notice.

By signing below, the patient and/or guardian acknowledges and agrees to the terms as written above.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_