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MVMT
MOVEMENT SPECIALISTS
PHYSICAL THERAPY

4532 W Napoleon Ave. Suite 101, Metairie, LA 70001
ph: 504.302.9700 fax: 504.302.9800

3701 LA - 59, Suite A, Mandeville, LA 70471
ph: 985.951.2006 fax: 985.951.2013

## Patient Information

*First Name* _____ *Last Name* _____ *Preferred Name* _____
*Date of Birth* _____ *Age* _____ *SS#* _____ *Cell Phone #* _____
*Current Mailing Address* _____ *City* _____ *State* _____ *Zip* _____
*Gender* ☐*Male* ☐*Female* ☐*Decline to answer* *E-mail* _____
*Preferred Pronouns* ☐*He/him* ☐*She/her* ☐*They/them* ☐*Other*
*Marital Status* ☐*Single* ☐*Married* ☐*Divorced* ☐*Widowed*
*Occupation* *Employer* _____
*How did you hear about us?* ☐*Doctor* ☐*Family/Friend* ☐*Google* ☐*Social Media* ☐*Returning Patient* ☐*Other*

## Consent to Communicate Electronically

By providing my phone number and email address, I understand that authorized personnel of this physical therapy practice may communicate with me regarding my scheduling, treatment, health education, billing, and promotional information.

_____
**Please Initial**

## Insurance Information

Billing Information ☐I am billing my insurance for these services ☐I am not using Insurance for these services
Do you have Medicare? ☐ Yes ☐ No If yes, are you enrolled in Home Health Physical Therapy? ☐ Yes ☐ No
Have you had physical therapy anywhere else this year? ☐ Yes ☐ No If yes, where? _____ # of visits? _____
Is this visit injury-related? ☐ Yes ☐ No If yes, ☐Work ☐Car Accident ☐Sports ☐Other/Personal Injury/Litigation
Attorney Name & Phone # associated with your injury _____
Primary Insurance Company Name _____
Secondary Insurance Company Name _____

**Please give the receptionist your ID and insurance card to copy**

## Physician Information

*Referring MD Name* _____ *Phone* _____ *Next Appt.* _____

## Emergency Contact Information

Name _____ Relationship _____ Phone _____

**The above information is true and correct to the best of my knowledge. I authorize my insurance benefits to be paid directly to Movement Specialists Physical Therapy, and I understand I am financially responsible for any remaining balance.**

_____ _____
Patient, Parent, Guardian or Representative Signature Date

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*Patient Name* _____

## *Past Medical History*

Have you ever had any of the following conditions? Check all that apply.

☐High blood pressure ☐Heart condition ☐ Stroke ☐Osteoporosis ☐Peripheral Neuropathy ☐Seizures/epilepsy
☐Vision problems ☐Diabetes ☐Hearing problems ☐Fainting/dizziness ☐Emphysema ☐Frequent or severe headaches
☐Bowel/bladder problems ☐Cancer ☐Arthritis ☐Asthma ☐Other _____

Have you had any falls in the past year? ☐Yes ☐ No If so, about how many? _____
Do you use an assistive device? ☐Yes ☐ No cane, walker, wheelchair, etc.. _____
Do you have a history of fractures? ☐Yes ☐ No Where? _____
Do you have any metal implants? ☐ Yes ☐ No Where? _____
Do you smoke? ☐ Yes ☐ No How much per day? _____
Do you drink alcohol? ☐ Yes ☐ No How much per day/week? _____
Do you exercise regularly? ☐ Yes ☐ No How often? _____
Do you have any known allergies? ☐ Yes ☐ No Please list _____
Are you pregnant or think that you might be? ☐ Yes ☐ No

## *Medications*

*Please list any medications (prescribed or over-the-counter) or supplements that you are currently taking.* _____

_____

_____

## *Surgeries*

*Please list all surgeries including dates.* _____

_____

## *Current Condition*

*What is the problem you are here for?* _____
*What is the date when the problem started?* _____
*Have you had similar symptoms before?* _____
*Have you seen anyone else for your <u>current</u> condition?*
☐*Physician / MD* ☐*Chiropractor* ☐*Podiatrist* ☐*Orthopedic Surgeon* ☐*Dentist* ☐*Neurologist* ☐*Physical Therapists* ☐*Other*

*Please check any tests or procedures that have been done for your current condition.*
☐*X-rays* ☐*MRI* ☐*CT scan* ☐*Bone scan* ☐*EMG* ☐*Blood work* ☐*Bone density* ☐*Ultrasound*

*Please check any of the following medical or rehabilitative services done for your current condition.*
☐*Acupuncture* ☐*Injections* ☐*Chiropractic* ☐*Massage Therapy* ☐*Occupational Therapy* ☐*Physical therapy*
☐*Emergency Room Care*

*Is there anything else you would like to tell us about your condition?* _____

_____

_____

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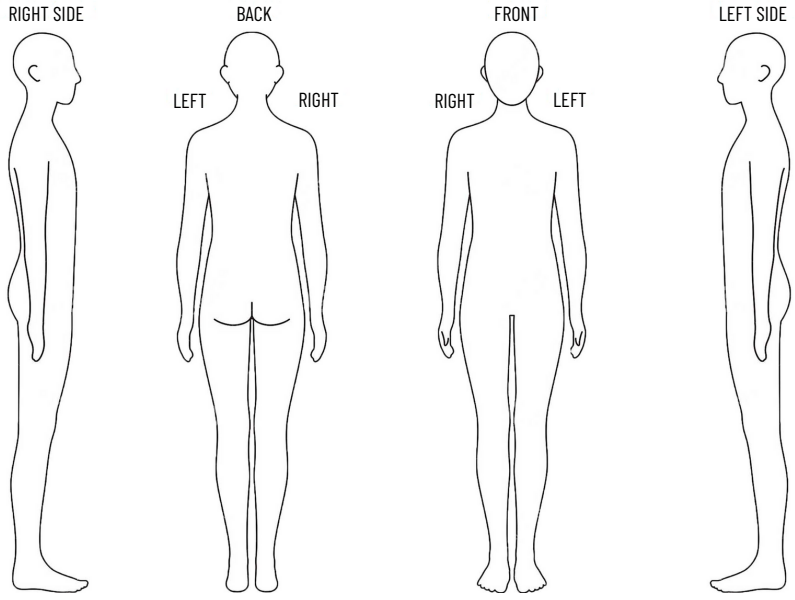
*Patient Name* _____

## *Where Is Your Pain?*

*Please mark on the drawing below, the areas where you feel pain as related to the reason for your visit/referral to physical therapy.*




## *Rate your Pain*

*Rating from 0 (none) to 10 (severe, worst pain imaginable) please rate your CURRENT pain level.*

*0 1 2 3 4 5 6 7 8 9 10*

*Rating from 0 (none) to 10 (severe, worst pain imaginable) please rate your pain level when it is at its BEST.*

*0 1 2 3 4 5 6 7 8 9 10*

*Rating from 0 (none) to 10 (severe, worst pain imaginable) please rate your pain level when it is at its WORST.*

*0 1 2 3 4 5 6 7 8 9 10*

## Symptoms

Please check any of the following that describe your pain symptoms.

☐*Sharp* ☐*Shooting* ☐*Burning* ☐*Dull* ☐*Throbbing* ☐*Pulling*
☐*Ache* ☐*Tingling* ☐*Numb* ☐*Heavy* ☐*Tight* ☐*Stabbing* ☐*Pins and Needles*

## *Frequency*

Please check any of the following that describe your pain frequency.

☐*Never goes away* ☐*Daily or several times a week* ☐*Once a week* ☐*Less than once a week*

## *Activities*

What activities make your pain worse? Please check ALL that apply to you.

☐Lying ☐Standing ☐Sitting ☐Walking ☐Exercise (during) ☐Exercise (after) ☐Bending Forward ☐Bending Backward
☐Twisting ☐Coughing/Sneezing ☐Other _____

What reduces your pain? Please check ALL that apply to you.

☐Lying ☐Standing ☐Sitting ☐Walking ☐Exercise (during) ☐Exercise (after) ☐Bending Forward ☐Bending Backward
☐Twisting ☐Coughing/Sneezing ☐Other _____

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# *Consent to Treat and HIPPA Form*

*Patient Name* _____

To help us provide you with the best possible care, please complete the following information.

Acknowledgment of Receipt of Notice of Privacy Practices: I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain privacy rights regarding my protected health information. I understand that this information can and will be used to: carry out, plan, and direct my treatment and follow-up care among the many healthcare providers who may be directly or indirectly involved in that treatment. Obtain payment from third-party payers. Conduct normal healthcare operations such as quality assessments and internal audits. I am aware that Movement Specialists Physical Therapy has the right to change its Notice of Privacy Practices from time to time, and I may contact my physical therapy office at any time to obtain a current copy of the Notice of Privacy Practices

I understand that I may request in writing that Movement Specialists Physical Therapy limit the disclosure of my private health information for treatment, payment, or health care operations.

_____
**Please Initial**

Consent for Treatment in a Group Setting: Movement Specialists Physical Therapy, following federal HIPAA regulations, is committed to protecting the health information and privacy of our patients. The therapists and staff will make every effort to ensure that your protected health information is kept private. However, due to the open nature of our therapy area, your treatment may be conducted in the presence of others. In some cases, other patients, family members, friends, or staff may overhear information regarding your treatment, diagnosis, and insurance benefits. Unless you indicate otherwise in writing, by signing the Consent Form, you agree that other patients may overhear some information regarding your treatment, and you consent to the disclosure of such information to any other person who may be present in the treatment area.

_____
**Please Initial**

The HIPAA privacy rule gives patients the right to ask for restrictions on how their protected health information (PHI) is used and shared. Patients can also ask for confidential communication or alternative ways of communication, like receiving mail at their workplace instead of their home. Hello! As a friendly reminder, healthcare providers are required to limit the use, disclosure, and requests for PHI to the minimum necessary to achieve the intended purpose, as required by the Privacy Rule. Thank you! However, authorizations requested by the individual are exempt from these provisions. It's important to note that PHI disclosures must be recorded by healthcare entities. If you complete the information properly, it will create an adequate record.

_____
**Please Initial**

I give Movement Specialists Physical Therapy permission to provide treatment as prescribed based on the findings during my treatment. I have let my therapist know about any pregnancies, metallic or electronic implants, serious illnesses or conditions, including osteoporosis, cancer, or communicable diseases.

_____
**Please Initial**

I confirm that everything I have shared is true to the best of my knowledge, and I agree with the policies of Movement Specialists Physical Therapy. I also authorize direct payment to Movement Specialists Physical Therapy for any services provided to me.

_____
**Please Initial**

_____ _____

Patient, Parent, Guardian or Representative Signature Date