SIMPLY RESULTS

YOUR BEST MOVES, PUT TOGETHER, FOR GOOD.

9 Williamsburg Lane, Chico, CA 95926
530-891-4456 FAX 530-345-3375
EMAIL office@simplyresultspt.com
WWW.SIMPLYRESULTSPT.COM

Welcoming New Patients

Please complete the following forms.

After the forms are complete, please fax, email, snail mail, or bring them to our office.

- If you stop by the office and the front desk is unattended, please place your forms in the lockbox in the reception area.
- If you stop by the office and we are closed, please put your forms through the mail slot, and we will attend to them the next business day.

Keep your phone close by over the next 5 business days, so you will be able to take a call from our office to get you scheduled for care.

Please make sure your voicemail is not too full for us to leave you a message.

Thank You!

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Patient Information *(please print clearly in blue or black ink)*

Patient Name (full):_____ **Date:**_____

Mailing Address:_____

City:_____ **State:**_____ **Zip:**_____ **Email Address:**_____

Any questions for a physical therapist before scheduling **(circle one)**? Yes No

Best time for scheduling call **(circle all that apply)**: 7am-9am 9am-4pm 4pm-6pm

Availability for appointments **(circle all that apply)**: Mornings Afternoons Mon Tues Wed Thur Fri

Check box of preferred contact number

☐ Home ph: _____ ☐ Work ph:_____ ☐ Other ph:_____

Birth date:_____ **Sex:**_____ **Marital Status:**_____

Occupation(s) current or past:_____

Employment Status (circle one): Full Time Part Time Retired

Who referred you to physical therapy?_____ Phone:_____

Primary Care Physician:_____ Phone:_____

Financially Responsible Person *(Check this box if the same as above)* ☐

Insured (first and last):_____ Relationship:_____

Address:_____ City:_____ State:_____ Zip:_____

Home phone:_____ Work phone:_____ Other phone:_____

Birth date:_____ Sex:_____ Marital Status:_____

Name of Insurance Provider:_____

Insurance Member ID:_____

Emergency Contact (first and last):_____

Relationship:_____ Phone:_____

If referred by the VA/CCN, list the last 4 digits of your Social Security number:_____

Medical History page 1 of 2 Date:_____

Patient Name: _____

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

Women:

Number of Pregnancies:

Number of Vaginal Births:

Any episiotomies or tearing?:

Men:

Prostate cancer?:

Describe any other Conditions or Precautions:

Falls History: Injury as a result of a fall in the past year? YES NO Date of Fall: _____

Two or more falls in the last year? YES NO Date(s) of Falls: _____

Please list any Home Falls Hazards you or others have identified:

 Date:_____

Patient Name: _____

Have you ever tested positive for Tuberculosis? YES NO **If yes, what year?**_____

Are you currently vaccinated against COVID-19? YES NO **If yes, have you had the booster?** YES NO

You may submit a separate list of your surgeries, if you have one for us to enter, but we are required to have the following information:

Surgical History:

Body region:	**Surgery Type:**	**Month/Day/Year:**
Body region:	**Surgery Type:**	**Month/Day/Year:**
Body region:	**Surgery Type:**	**Month/Day/Year:**
Body region:	**Surgery Type:**	**Month/Day/Year:**
Body region:	**Surgery Type:**	**Month/Day/Year:**

You may submit a separate list of your current medications, if you have one for us to enter, but we are required to have the following information:

Current Medications:

Drug:	**Dosage:**	**Frequency:**	**Route:**	**Reason for taking:**
Drug:	**Dosage:**	**Frequency:**	**Route:**	**Reason for taking:**
Drug:	**Dosage:**	**Frequency:**	**Route:**	**Reason for taking:**
Drug:	**Dosage:**	**Frequency:**	**Route:**	**Reason for taking:**
Drug:	**Dosage:**	**Frequency:**	**Route:**	**Reason for taking:**
Drug:	**Dosage:**	**Frequency:**	**Route:**	**Reason for taking:**

Please enter your height (_____ feet, _____ inches), as well as your current weight (_____ pounds.) Thank you.

PLEASE share in your words why you're here, and your goals for during and after the physical therapy process.

Please Initial(_____) **Acknowledgment of Privacy Notice Receipt:**
For patient information, there is always in the waiting room a copy of the "Notice of Privacy Practices for Simply Results Physical Therapy, with an effective date of September 20, 2013" I understand that I may have a copy of the privacy notices at any time for my own files.

Please Initial(_____) **Informed consent for evaluation and to start physical therapy treatment today, for the use of Simply Results Physical Therapy's courtesy billing service, and acknowledgement of my responsibilities as a patient:**

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy for me will be determined during the first visit and will be explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

Potential risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my therapist so that treatment can be adjusted accordingly.

Alternatives: If I do not wish to participate in the therapy program, I will say so to the physical therapist. Also, I will continue to discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

No warranty: I understand that the physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss all treatment options with me before I consent to treatment.

Cooperation with treatment: I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent attendance. I agree to cooperate with and carry out the home program assigned. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

Please Initial(_____) **Permission to leave message:** I authorize the routine practice of leaving a message on my answering machine as needed, and/or sending a text, and/or sending an email to confirm my appointments or to relay other information as needed to coordinate care.

Please Initial(_____) **Cancellation Policy:** People on our waiting list are in pain and urgently need to be seen, and they also need time to make arrangements. On behalf of those in need of care, we respectfully request that you allow **ONE WEEK ADVANCE NOTICE** of any appointment changes to time or day whenever possible, or as soon as possible if an emergency arises.

Please Initial(_____) **Health History Completed:** I have informed my therapist of any condition that would limit my ability to have an evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists at Simply Results Physical Therapy.

Please Initial(_____) **Plan of Care Agreement:** My diagnosis, evaluation findings including the treatment program, the expected benefits or goals of treatment, and reasonable alternatives to the recommended treatment program, will all be explained by the PT as information is gathered. I am willing to ask questions about my care until my questions are answered to my understanding and satisfaction so I can consent to the recommended course of treatment. Returning for follow-up visits demonstrates agreement to the plan of care.

Please Initial(_____) **Release of medical records/discuss with physician:** I authorize the release of my medical records to my physicians/primary care provider or insurance company. The PT is allowed to discuss my medical condition with my referring physician, with the permission I assign today. Also, other records, from any other facility where I have been treated, are authorized for release.

Please Initial(_____) **Assignment of Benefits and Release of Medical Information:** I hereby authorize payment of medical benefits to SIMPLY RESULTS PHYSICAL THERAPY, INC for services rendered to my dependents or myself. I also authorize the release of any medical information that is necessary to process Medicare and/or insurance claims. I understand that I am responsible for any amount not covered by insurance within 60 days of service, and finance charges/fees will be assessed on overdue balances. I understand that a copy or facsimile of this authorization can be used in place of the original. This assignment will remain in effect until revoked by me in writing.

Patient Signature:_____Patient Name:_____

(Please Print)

Signature of Parent or Guardian (If applicable)_____

Date:_____

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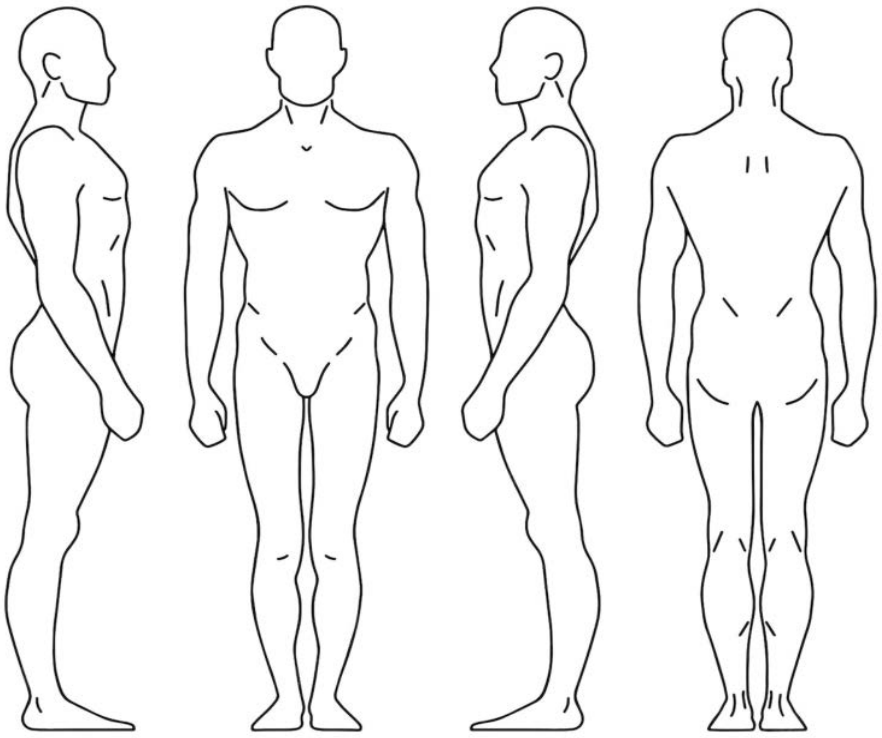
Holistic Health History: Whole-Body Approach

What are you dealing with?

Please mark on the body below where you've had issues, both **now** and **in the past**.



Use a HIPAA-compliant method to get us this info, ASAP:

By Mail: Simply Results Physical Therapy • 9 Williamsburg Lane • Chico, CA 95926

By Fax: 530-345-3375. Questions? 530-891-4456. Email: office@simplyresultspt.com

OPTIONAL INTAKE PAGE

Holistic Health History—Whole-Body Approach—Brainstorming Pages

Can you recall any problems with:	if so, when?	for how long?
Bladder?		
Bowel?		
Dizziness?		
Weight?		
Sleep?		
Pelvic Floor?		
Scar Tissue?		
Anxiety?		
Depression?		
Pain?		
Injury?		
Major Medical?		

LIST: Where are you falling apart? What happens? Be as descriptive as you wish. It is all relevant. Past, Present, and Future; Body, Mind, Spirit; Work, Play, and Relationships.

1	
2	
3	
4	
5	

OPTIONAL INTAKE PAGE

GOALS: what do you want? Please brainstorm and list your thoughts, hopes and dreams… anything that arises. Be as descriptive as you wish. It is all relevant.

1	
2	
3	
4	

TESTS: How will you know you're there? How will you be feeling? What will you be doing?

1	
2	
3	
4	

Anything else?

What work did/do you do in life? Past/present occupation? Hobbies?