Tower PT
& Restorative Wellness

First Name ____________________________ Last Name ____

Date of Birth _____/____ _/______ _ Age ________ Weight: ______ __ Height: ____', ____" Sex: M F

Email: ____ Referred By:__________________________________

Home Phone: ( ) ______-___________ Work/Cell Phone: ( ) __________-_____________

Address ____

City _____________________________ State ________ Zip ___________

Occupation: ____________________________________Employer: _______________________________________

Sports/Activities:____

Injury Area: _____________________________ Date of injury/onset ______________

Accident Related? Y N If Yes, Select MVA ☐ Fall ☐ Sports Related ☐ Worker's Compensation ☐

Emergency Contact _____________________________________Phone: ( ) ________-__________________

Are you receiving or have you recently received home health services? Yes No
Are you receiving or have you received other therapy services? Yes No

	Yes	No
Recent trauma or accident---------------	☐	☐
Recent Falls (last 2 years) ---------------	☐	☐
Recent blow to head ---------------------	☐	☐
Recent whiplash injury ------------------	☐	☐
Recent weight loss/gain -----------------	☐	☐
Recent surgery ---------------------------	☐	☐
Recent initiation of exercise program --	☐	☐
Recent Injection(s) ----------------------	☐	☐
Changes in bowel/bladder control ------	☐	☐
Osteoporosis ----------------------------	☐	☐
Immunosuppressive disorder -----------	☐	☐
Rheumatoid arthritis --------------------	☐	☐
Currently on Antibiotics ---------------	☐	☐
Heart problems -------------------------	☐	☐
Diabetes ---------------------------------	☐	☐
Hypertension ---------------------------	☐	☐

	Yes	No
Fever, chills, and or night-sweats----------	☐	☐
Numbness in "saddle" area ----------------	☐	☐
Weakness ------------------------------------	☐	☐
Numbness/tingling in your arms/legs -----	☐	☐
Corticosteroid therapy/medication --------	☐	☐
Do you smoke ------------------------------	☐	☐
Difficulty breathing, coughing, sneezing -	☐	☐
Difficulty speaking ------------------------	☐	☐
Clumsiness/weakness in arms or legs -----	☐	☐
Headaches ----------------------------------	☐	☐
Difficulty concentrating -------------------	☐	☐
Dizziness ------------------------------------	☐	☐
Changes in vision --------------------------	☐	☐
Nausea/vomiting ---------------------------	☐	☐
Sensitivity to light /sound -----------------	☐	☐
History of Cancer --------------------------	☐	☐

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Please list any other major medical conditions not listed above:

____

____

____

Please List your medications:

____

____

In addition to physical therapy, what other services are you interested in: (Please check all that apply)
Massage Therapy ☐ Pilates ☐ Yoga Therapy ☐ Personal Training ☐ Sports Medicine ☐

What's your preferred method of appointment reminders? Text Message ☐ Email ☐
Wireless Carrier:____________________________

How did you find Tower PT and Restorative Wellness

Physician Referral: ☐ Name:_____________________________________
Friend/Family Referral: ☐ Name:_____________________________________
Internet: ☐ Site:______________________________________
Other: ☐ ____

Please initial after reading statements:

1. **Consent to Treatment:** I consent to rehabilitation and related services at Tower PT and Restorative Wellness. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. _________

2. **Liability:** I know and agree that Tower PT and Restorative Wellness is not responsible for loss or damage to personal valuables. ________

3. **Authorization of Payment:** I hereby assign all benefits directly to Tower PT and Restorative Wellness and authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I received, I will be financially responsible for payment. ______

4. **Cancellation Policy*:** Unless there is a medical emergency, same day cancellations are not accepted for scheduled appointments. Same day cancellations and/or no shows will be charged a fee of $75 per session. ___________

5. **Treatment of Minor**: I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. __________

**See our "Appointment & Payment Agreement Form" for details.*

Patient Signature: ____Date: __________________________

For office use only. FD Initials __________