American Fork Physical Therapy @ Vasa Fitness

636 East State Rd. ♦ American Fork, UT 84003 ♦ PHONE: (801) 492-6577 ♦ FAX: (801) 492-6579

Patient

Patient's Name Last	First	Middle	Name Preferred
Address of Patient	Apt. # City	State	Zip Code
Cell Phone Number	Home Phone Number	**Email Address**	
Social Security Number	Age / Birthdate / Sex M F	Marital Status Single Divorced Separated Married Widowed	
Employer Full Time Part Time	Occupation	Hire/Rehire Date	Employers Telephone Number
Employer Address:			
Who can we thank for this referral? Doctor Insurance Co. Yellow Pages **Friend/Family name:** _____ **Advertising:** _____			

Insured

Insured or Responsible Party	Relationship	Address	
Telephone Number	Sex M F / Birthdate	Social Security Number	Occupation
Employer Full time Part time	Address of Employer	Hire/Rehire Date	Employers Telephone Number

Spouse

Spouse's Name	Address	City	State	Zip Code
Telephone Number / Birthdate / Sex M F	Social Security Number	Employer	Employer Address	

Other

Relative/Friend Name	Address
Telephone Number / Sex M F	Relationship

Referring Physician	Primary Care Physician
Symptoms/Complaint	**Date of Surgery:** _____

Accident

Date Time	Auto Yes No	Industrial Yes No
How & Where Did the Accident Occur?		

Insurance Info

Private Pay/No Insurance	Medicare ID #	Medicaid #
Primary Insurance Name		Secondary Insurance Name
Insurance Address		Insurance Address
Group # / ID #		Group # / ID #
Policy Holders Name / Ins Phone Number		Policy Holders Name / Ins Phone Number
Group Thru What Employer		Group Thru What Employer

Consent for Treatment

I, the undersigned, a patient of American Fork Physical Therapy, do hereby authorize treatment to be administered as necessary. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that as a courtesy AFPT will prepare insurance forms and bill my insurance company directly by way of electronic (EDI) or paper claims. I hereby request assignment of payment of all insurance benefits to AFPT. I am ultimately responsible for payment of all services rendered, unless otherwise provided by law.

_____ _____

Patient or Legal Guardian's Signature Date

Signature required on back side of document

Deductibles/Co-Insurance and/or Co-Payments

Co-payments are to be paid at time of service, unless prior arrangements have been made with the Office Manager. **Deductible** and Co-Insurance payment amounts will be billed at the time the payment from your insurance company is received. Payment is due within 30 days of the invoice. Patients are to keep payments current. In the event the account goes into default the patient agrees to pay all collection costs, including but not limited to: attorney fees, court costs and a collection fee of 40% of unpaid balance. Payment plans are available to those who request it if you would like more information please speak with the secretary.

_____ _____

Patient or Legal Guardian's Signature Date

No-Show/Cancellation Policy

We understand that life happens. If for any reason you are not able to keep your appointment, please give our office 24-hour notice. If you are unable to cancel and miss an appointment, we reserve the right to charge you a $25.00 no-show/cancellation fee beginning on the 2nd missed appointment.

_____ _____

Patient or Legal Guardian's Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name:_____ **MR Number:**_____

Address:_____

Office Name: American Fork Physical Therapy

I have been □ given a copy □ been offered a copy of American Fork Physical Therapy's (AFPT) Notice of *Privacy Practices("Notice")*, which describes how my health information is used and shared. I understand that AFPT has the right to change this Notice at any time. I may obtain a current copy by contacting the Office Compliance Officer, or by visiting the AFPT website at www.afphysicaltherapy.com.

My signature below acknowledges that I have been □ given a copy □ been offered a copy of the Notice of Privacy Practices:

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name

_____

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

With whom can we discuss your PHI? Please give full names. Please put any names you want us to be able to make appointments, payments, or discuss any PHI at all.
If the name is not written here, we will be unable to speak to them.

A _____

_____

_____

_____

_____

For Office Use Only: Complete this section if you are unable to obtain a signature.

1. **If the patient or personal representative is unable or unwilling to sign this *Acknowledgement,* or the *Acknowledgement is not signed for any other reason, state the reason:***

_____

_____

_____

2. **Describe the steps taken to obtain the patient's (or personal representative's) signature on the Acknowledgement:**_____

_____

Completed by:

_____ _____

Signature of Office Representative **Date**

_____

Print Name

VASA FITNESS ACCIDENT WAIVER AND RELEASE OF LIABILITY FORM

I HEREBY ASSUME ALL OF THE RISKS OF PARTICIPATING IN ANY/ALL ACTIVITIES ASSOCIATED WITH THE USE OF THE EXERCISE FACILITY AND SWIMMING POOL LOCATED AT VASA FITNESS IN ASSOCIATION WITH AMERICAN FORK PHYSICAL THERAPY, including by way of example and not limitation, any risks that may arise from negligence or carelessness on the part of the persons or entities being released, from dangerous or defective equipment or property owned, maintained, or controlled by them, or because of their possible liability without fault.

In consideration of my participation in this activity, I hereby take action for myself, my executors, administrators, heirs, next of kin, successors, and assigns as follows:

(A) I WAIVE, RELEASE, AND DISCHARGE from any and all liability, including but not limited to, liability arising from the negligence or fault of the entities or persons released, for my death, disability, personal injury, property damage, property theft, or actions of any kind which may hereafter occur to me including my traveling to and from this activity while receiving physical therapy services from American Fork Physical Therapy THE FOLLOWING ENTITIES OR PERSONS: Vasa Fitness and/or their directors, officers, employees, volunteers, representatives, and agents, and the activity holders, sponsors, and volunteers;

(B) INDEMNIFY, HOLD HARMLESS, AND PROMISE NOT TO SUE the entities or persons mentioned in this paragraph from any and all liabilities or claims made as a result of participation in this activity, whether caused by the negligence of release or otherwise while receiving physical therapy services from American Fork Physical Therapy.

I acknowledge that Vasa Fitness and their directors, officers, volunteers, representatives, and agents are NOT responsible for the errors, omissions, acts, or failures to act of any party or entity conducting a specific activity on their behalf.

I acknowledge that this activity carries with it the potential for death, serious injury, and property loss. The risks include, but are not limited to, those caused by terrain, facilities, temperature, weather, condition of participants, equipment, vehicular traffic, and actions of other people including, but not limited to, participants, staff, and volunteers.

I hereby consent to receive medical treatment which may be deemed advisable in the event of injury, accident, and/or illness during this activity.

The Accident Waiver and Release of Liability Form shall be construed broadly to provide a release and waiver to the maximum extent permissible under applicable law.

I CERTIFY THAT I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND ITS CONTENT. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT AND I SIGN IT OF MY OWN FREE WILL.

Participant's Signature (Please print legibly.)	Date	Participant's Name	Age

Parent/Guardian Signature	Date

(If under 18 years old, Parent or Guardian must also sign.)

MEDICAL HISTORY SCREENING FORM

American Fork Physical Therapy @ Vasa Fitness

Name:_____ Date:_____

Injury onset date: _____ Start of care: _____

Treatment Side: Left Right N/A

Surgery performed? Yes....No Date of surgery: _____

Type of surgery: _____

Referring physician: _____

Height: _____ Weight: _____

Is this the first time you've been seen for this injury? (i.e. have you seen a doctor, chiropractor, etc.) Yes.....No

Have you been seen by a Home Health company? Yes.....No

If so, what day were you discharged?_____

Name of the Company?_____

Have you been seen by another Physical Therapist this year? Yes.....No

If so, approximately how many visits?_____

How did your injury occur? Be specific with activity, location.

_____

_____

What is your main concern/complaint?

_____

_____

_____

Pain Scales:

Location: _____

0 = None 5 = Moderate 10 = Extreme

0 1 2 3 4 5 6 7 8 9 10

Amount pain is experienced through the day: _____%

Pain description (circle all that apply):

Burning	Sharp	Dull/achy
Throbbing	Shooting	Numbness/tingling
Constant	Intermittent ____%	Worse in AM/PM

Other:_____

What makes your symptoms worse? (circle all that apply)

Sitting	Standing	Walking
Going up stairs	Going down stairs	Sit to stand
Bending	Voiding	Laying down
Cough/sneezing		

Other:_____

What makes your symptoms better? (circle all that apply)

Bending	Sitting	Turning
Rising	Standing	Walking
Laying	AM	As day progresses
PM	When still	On the move

Other: _____

FOR OFFICE USE ONLY:

ROMS: _____ SCORE: _____

Have you ever been told that you have:

Osteoarthritis?.....	Yes...No
Rheumatoid Arthritis?.....	Yes...No
Cardiovascular Disease?.....	Yes...No
Diabetes Mellitus Type 1 or 2?.....	Yes...No
Pregnancy/Possibility of current?.....	Yes...No
Allergies?	Yes...No
High blood pressure?.....	Yes...No
Angina/Chest pain?.....	Yes...No
Stroke?.....	Yes...No
Osteoporosis?.....	Yes...No
Pacemaker?.....	Yes...No
Epilepsy/Seizure disorder?.....	Yes...No
Cancer/history of?.....	Yes...No
Have you sustained a fall in the last 6 months?	Yes...No

What medications are you currently taking (prescriptions, over the counter, herbs, vitamins, etc.)? Please include dosages

Medication	**Dosage**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are there any medications that you should be taking that you are not? ❑ Yes ❑ No

If yes, please list:_____

What are your goals for Physical Therapy?

_____

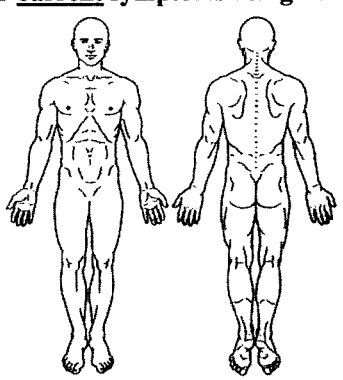
_____

If you have undergone surgery, please list it below.

Surgery?	When?	Still having problems?
_____	_____	Yes.....No
_____	_____	Yes.....No
_____	_____	Yes.....No
_____	_____	Yes.....No

Please describe your <u>current</u> symptoms using the following key.

Aching: aaa
Burning: bbb
Numbness: nnn
Sensitivity: sss
Tingling: ttt
Stabbing: ///
Other: ppp



MEDICAL HISTORY SCREENING FORM – FUNCTIONAL ASSESSMENT

American Fork Physical Therapy @ Gold's Gym

Name:_____ Date:_____

BEFORE YOUR SYPMTOMS BEGAN:

Did you have any limitations with day-to-day activities?

☐ No

☐ Yes

If you marked yes, please describe what you had difficulty with and what may have been the cause:

_____

_____

_____

_____

_____

_____

_____

Before your problem started or began to worsen, how long could you do each of the following?

Sitting: _____ Standing: _____

Walking: _____ Laying: _____

Before your problem started or began to worsen, how much could you lift comfortably?

I could not lift at all Less than 10 lbs. 10 lbs.
20 lbs. 30 lbs. 40 lbs. 50 lbs. 60 lbs.
70 lbs. 80 lbs. 90 lbs. 100 lbs.
More than 100 lbs.

Please identify any tasks you currently have difficulty completing

SINCE YOUR SYMPTOMS BEGAN:

Self Care:

Hygiene Sleep Household chores
Laundry Cooking Driving
Caregiving Other: _____

Mobility:

Used assistive device Climbing Running
Walking Moving around Jogging
Skipping Jumping Swimming
Moving between rooms Going down the street Walking within a building
Moving around in crowded room Walking on uneven terrain
Other: _____

Changing or Maintaining Body Positions:

Remain seated Remain standing Squatting
Kneeling Sitting Standing
Moving from bed to chair Sliding along a bench
Other:_____

Carrying, Moving and Handling Objects:

Pulling objects Pushing objects Reaching
Throwing Catching Turning/twisting hand/arm
Picking up items Grasping Releasing
Kicking Pushing with legs
Work/occupational requirements: _____
Other: _____

How long can you CURRENTLY do each of the following before you need to stop or do something else?

Sitting: _____ Standing: _____

Walking: _____ Laying: _____

How much can you lift comfortably at this time?

I could not lift at all Less than 10 lbs. 10 lbs.
20 lbs. 30 lbs. 40 lbs. 50 lbs. 60 lbs.
70 lbs. 80 lbs. 90 lbs. 100 lbs.
More than 100 lbs.