Terrapin Physical Therapy
Attendance Agreement

Your Physical therapy appointments are exclusively reserved for you and

are typically 60 minutes in duration.

Not arriving for a scheduled appointment time or providing insufficient notice when canceling an appointment places a hardship on your recovery and other patients in need of our services, as well as Terrapin Physical Therapy's ability to compensate our team.

We respectfully require patients to provide at least 24 business hour notice when canceling or changing an appointment to another day.
Without exception and regardless of the circumstances any No Show, arrival time which does not allow for sufficient treatment time, or appointment canceled under 24 hours from the time of your scheduled appointment will incur a $50.00 fee.

Private insurance will not cover missed appointment fees, and therefore, will not be billed. Private insurance companies do allow for this to be billed directly to the patient; you will be responsible for payment in full prior to or at the time of your next scheduled appointment. Check, Credit/Debit card, and Money Order are accepted; cash is not accepted.

You may call our office at (831) 372-3579 Monday through Saturday 8-6 to cancel or change an appointment.

If you have more than 3 missed appointments, please understand that this severely interrupts our ability to meet your health care needs as well as our office scheduling and may result in your being discharged from care at our office.

Patient Signature: ______________________________ Date:________

Thank you for choosing Terrapin Physical Therapy.

In order to best serve you please provide the following information.

First Name: ________________________ **MI:**________ **Last Name**______________________________

Prefered Name:___________________**Sex:** M F **Driver's License/ ID:**___________________**Exp:**___

Address:_______________________________________**City:**_________________**State:**______**Zip:**___

☐ ***I would like to receive text messages alerts for appointment reminders.***

☐ ***I would like to receive E-mail alerts for appointment reminder.***

Mobile Phone:___________________________**Home Phone:**______________________________

E-Mail:__________________________________**Date of Birth:**______________**SSN:**________________

Emergency Contact:_______________________**Relationship:**_______________**Phone #:**____________

Employers Name:_________________________**Profession:**________________**Work Phone:**_________

Work Comp Claim #:___________________________________**Injury Date:**______________________

Primary Insurance: ____

Subscriber Name:______________________________________**Subscriber Date of Birth:**____________

Subscriber SSN:______________**Subscriber ID:**____________________**Group Number:**_____________

Secondary Insurance: ____

Secondary Name:______________________________________**Subscriber Date of Birth:**____________

Subscriber SSN:______________**Subscriber ID:**____________________**Group Number:**_____________

Assignment of Benefits: I hereby authorize my insurance benefits to be paid directly to Terrapin Physical Therapy INC, and I understand I am financially responsible for all non-covered services. I also authorize Terrapin Physical Therapy INC to release any information to process this claim.

Signature; Parent/Guardian:____**Date:**______________

How did you learn about Terrapin Physical Therapy?

My Doctor Lawyer Former Patient Returning patient Print Advertisement

Website Google Facebook Yahoo Yelp

Walked by your Office Community Education In-service

Creating Happiness and Health since 2005!

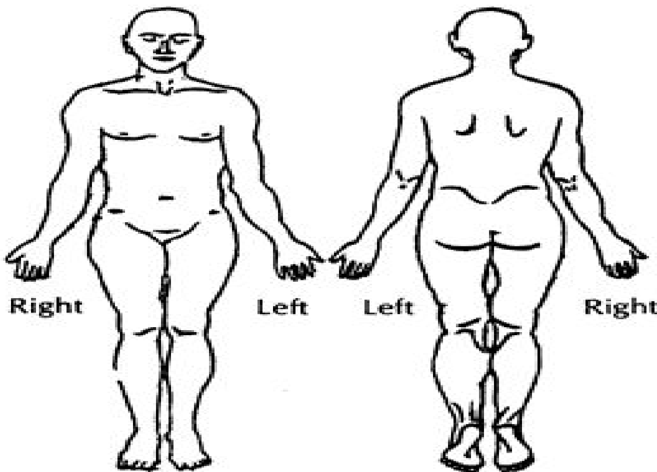
Terrapin
PHYSICAL THERAPY

NAME ___________________________________ **Date______________________**

HEIGHT___________________

WEIGHT___________________

1. **When did your present symptoms begin (approximately)? Date: ____/____/_____**
2. **Was there a specific event or trauma that brought on your symptoms? YES / NO**
   If yes, describe:____
3. **Have you had similar symptoms in the past?** YES NO
4. **Did you have surgery?** YES NO
   If yes, on what date? ____/____/______ What kind of surgery?_________________
5. **What symptoms bring you into the clinic today?**__________________________________
6. **Was this a work-related injury?** YES NO
   If yes, describe:____
7. **Does your problem affect your sleep?**YES NO
8. **<u>Use the "X" symbol to mark your symptomatic area(s) on the body chart below.</u>**



9. **<u>How would you describe your symptoms?</u>** (Circle all that apply)
   Sharp Dull/Achy Shooting Numb/Tingling Burning Other:_________________
10. **<u>Do any of the following activities AGGRAVATE your symptoms?</u>** (Circle all that apply)
   Sitting Standing Walking Stairs Bend Cough/sneeze Gripping Lifting
   Sit to Stand Twisting lying Down Deep Breath Eating foods Other:___________ Pinching
11. **<u>What helps EASE your symptoms?</u>** (Circle all that apply)
   Ice Heat Medication Sitting Standing Lying Down Other:____________
12. **<u>When are your symptoms best?</u>** (Circle one)
   morning afternoon evening no change
13. **<u>Since your symptoms began are they getting:</u>** (Circle one)
   better worse no change
14. **Have you had a fall in the last year?** YES NO
   If yes, did you sustain an injury from the fall? YES NO
15. **Have you had 2 or more falls in the last year?** YES NO

Name: **Date:**

16. Have you RECENTLY experienced any of the following: (circle all that apply)

Fatigue Weight change Fever/chills/sweats Dizziness Nausea Weakness

Balance Problems Changes in mentation Malaise

Difficulty urinating Irregular menstrual cycle numbness/tingling

Change in bowel/bladder Shortness of breath Headaches

Abdominal pain Change in urine color

17. Have you EVER had, or been told you have, any of the following? (Circle all that apply)

Cancer	Osteoarthritis	Neurologic Disorders
Diabetes Type I	Rheumatoid Arthritis	Lung Disease
Diabetes Type II	Osteoporosis	Liver/Kidney problems
Angina/Chest pain	Blood clot	Acid reflux
Shortness of breath	Asthma/Allergies	Abdominal pain
Fibromyalgia	Circulation Problems	Ulcers
Stroke	Multiple Sclerosis	Parkinson's Disease
Heart Disease	Pregnant	Pacemaker

18 Are you CURRENTLY receiving any other treatment for this or any other condition (home health, Speech therapy, physical therapy, chiropractic., etc)? YES NO

If yes, what kind of treatment?______________________________

19. Have you had PREVIOUS treatment as described above for this problem? YES NO

If yes, what kind of treatment?______________________________

20. Have you EVER had surgery? YES NO

21. If yes, please list surgery type and approximate date

____

22. How often do you exercise: seldom/never 1-2 times per week 3 or more times per week

23. How many drinks do you have per week? _______

24. Do you smoke? YES NO

25. Have you had imaging studies? (circle all that apply)

None XRAY MRI CT Scan Other:________________

26. Have you EVER used corticosteroid medication (such as prednisone or cortisone)? YES NO

27. Current Medications:

28. Please check your response to each of the following questions:

During the past month have you often been bothered by feeling down, depressed or hopeless? YES NO

During the past month have you often been bothered by little interest or pleasure in doing things? YES NO

If yes to above, have you recently had thoughts of harming yourself or others? YES NO

30. Please list 3 normal activities that you are now limited in performing due to this current problem:

1.______________________________

2.______________________________

3.______________________________

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