NAME_____ SOCIAL SECURITY #_____ M ____ F_____

ADDRESS _____ CITY _____ CA _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

DATE OF BIRTH _____ AGE _____ DRIVERS LICENSE # _____

EMPLOYER NAME _____

OCCUPATION/ POSITION _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____

RELATIONSHIP_____ PHONE # _____

MESA PHYSICAL THERAPY

MEDICAL HISTORY/SUBJECTIVE INFORMATION

A complete medical history is necessary for a thorough evaluation. Please answer the following questions.

Your Name:			**Today's Date:**
Height:	**Weight:**	**Blood pressure**	**Do you smoke? Yes No**
Sex: Male Female *If female,* **are you currently pregnant? Yes No** *If yes,* **1st Trimester 2nd Trimester 3rd Trimester**			

Have you ever been diagnosed with any of the following?

Tuberculosis	No	Yes	Cancer	No	Yes	Arthritis	No	Yes
Diabetes	No	Yes	Hepatitis	No	Yes	Stroke	No	Yes
Heart Condition	No	Yes	Epilepsy	No	Yes	Respiratory Problems	No	Yes

Other:_____

How did you hear about Mesa P.T.?_____

Tell us about your condition

When did you first notice the pain or have functional problems due to the condition/injury? *(Please provide approximate dates.)*_____

_____

_____

Recent flare-up? No Yes *If yes, when*_____

_____

_____

What activities are limited by this condition? *(example: lift, reach):*_____

_____

_____

_____

How did your injury/symptoms occur?_____

_____

_____

_____

What do you expect to accomplish with physical therapy?_____

_____

_____

Do you think you will get better?_____

_____

_____

Do you think physical therapy will help?_____

_____

_____

Is there a specific treatment you think will help?_____

_____

_____

MESA PHYSICAL THERAPY

Are your symptoms: Constant? Intermittent? Getting Better? Getting worse? Staying the same?

What makes your symptoms better? _____

_____

0-10 pain scale (0=No pain; 5= moderate pain; 10=The most extreme pain)

Worst pain rating: 0 1 2 3 4 5 6 7 8 9 10

Best pain rating: 0 1 2 3 4 5 6 7 8 9 10

For this injury, has your medical care included: (check those that apply)

Surgery: When? ___/ ___/ ___ What kind? _____

Injection: When? ___/ ___/ ___ Did it help? No Yes

Other treatment:

Physical or Occupational therapy If yes, when? __/ __/__ to __/__/__

What was done?_____

_____

Chiropractor If yes, when? __/__/__to __/__/__

What was done?_____

_____

Medications:_____

_____

_____

X-ray:_____ MRI_____

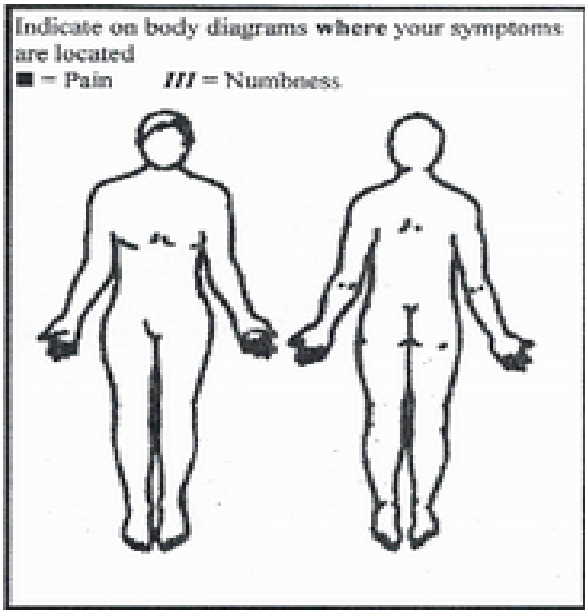
CT scan: _____ Other: _____

_____

Exercises: What kind? _____

_____

_____



MESA PHYSICAL THERAPY CURRENT MEDICATIONS LIST REPORT

PATIENT NAME:_____ DATE:_____

LIST ALL THE PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING;

NAME OF MEDICATION	**DOSAGE** *(How many or how much you take)*	**FREQUENCY** *(How often do you take it?)*	**ROUTE** *(How do you take it, ex.; by mouth, injection, etc)*

LIST ALL OVER THE COUNTER MEDICATIONS

NAME OF MEDICATION	**DOSAGE** *(How many or how much you take)*	**FREQUENCY** *(How often do you take it?)*	**ROUTE** *(How do you take it, ex.; by mouth, injection, etc)*

LIST ALL HERBALS, VITAMINS, MINERALS, NUTRITIONAL SUPPLEMENTS

NAME OF MEDICATION	**DOSAGE** *(How many or how much you take)*	**FREQUENCY** *(How often do you take it?)*	**ROUTE** *(How do you take it, ex.; by mouth, injection, etc)*

2018 Patient Signature

COMPANY NAME: Mesa Physical Therapy

PATIENT NAME: _____

____ *Consent for Care and Treatment*

I, the undersigned, hereby agree and give my consent for above named practice to furnish care and treatment considered necessary and proper in treating my condition.

____ *Authorization for Signature on File and Release of Information*

I, the undersigned, hereby authorize the office of above named practice to affix my name to any and all claims or documents as related to any and all health benefits due me. I authorize the release of any information relating to my health care claims. A photostatted copy of this authorization shall be as valid as an original.

____ *Authorization for Assignment of Benefits*

I, the undersigned, hereby assign all medical benefits, to which I am entitled, to the office of above named practice, and I shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to this office. I hereby authorize and instruct my insurance company to pay by check and mail directly to above named practice.

____ *Financial Responsibility*

I, the undersigned, understand and agree that if it becomes necessary to commence legal action, I am responsible for all costs of collecting moneys owed including court costs, collection agency fees and attorney fees, in addition to my outstanding account balance. I further understand that balances over 60 days will be subject to a 1.5% finance charge, for which I am personally liable.

____ *Cancellation Policy*

Specific time is reserved for you when you schedule an appointment. If you cannot keep your scheduled appointment, please give us at least 24 hours notice so that we may reschedule your appointment and offer the reserved time to another patient. There will be a charge of $25.00 for NO SHOW appointments or cancellations with less than 24-hour notification. I, the undersigned, understand that I will be personally responsible for any cancellation fees.

____ *Reminder Message*

I, the undersigned, hereby authorize the office of above named practice to send reminders to my mobile number, home phone, or email address of upcoming appointments.

I have read and fully understand all of the above information and hereby agree to comply as outlined above.

_____ _____

Patient or Guardian Signature Date

2018

PATIENT INFORMATION ACKNOWLEDGMENT FORM

COMPANY NAME: Mesa Physical Therapy

I have read and fully understand above named practice‘s Notice of Information Practices. I understand that above named practice may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that above named practice will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in above named practice‘s Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Date

I also authorize above named practice to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

_____
Patient Name

_____
Signature

_____
Date

.

2018

Information Release Authorization

Company Name: **Mesa Physical Therapy**

I hereby consent to the release and disclosure of my personal health information to:

Name: Mesa Physical Therapy

Address: 7510 Clairemont Mesa Blvd., Suite 103

City: San Diego State: CA Zip: 92111

Phone #: (858) 277-2277 Fax #: (858) 277-7358

For the following purpose:

_____

_____

_____

This release authorization includes my personal health information consisting of:

_____

_____

I understand that the information outlined in this release will be disclosed according to the instructions of this release within two (2) business days of the above practice having received this release authorization. I understand that I am free to revoke this release authorization at any time by notifying the practice in writing. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the Privacy Regulations (45 C.F.R. 164).

_____

Patient Name

_____

Signature *Date*

Dear Patient,

During the course of your treatment your therapist may recommend specific supplies to assist in your recovery. These are recommendations only, and you are under no obligation to purchase supplies from our office.

The following is a price list of commonly used supplies.

Exercise Equipment:

Foam Roll	$25
½ Foam Roll	$16
Overhead Pulley	$16
Putty	$10
Exercise Band (2 yds)	$5
Swiss Ball	
55cm	$46
65cm	$56
75cm	$63
Balance Disc	$40

Scar Management:

Cica Care Gel	
Full Sheet	$53
Single Strip	$14
Slipos Digi Sleeve	$6

Edema Management:

Compression Glove Single	$15
Compression Glove Pair	$25
Compression Sleeve	$13
Tubigrip (per foot)	$3
Coban 1 inch (per roll)	$2
Coban 2 inch (per roll)	$4
ACE Bandage 2”	$2

Wound Care:

Adaptic 3x3	$5
Xeroform 1x8	$2
Xeroform 5x9	$10
Stockinette (1 yd)	$2

Splinting:

Neoprene Wrist Wrap	$20
Cool Comfort CMC (short)	$35
D-Ring Wrist	$40
LMB Spring Extension	$25
Epicondylitis Strap	$23
Kinesiotape (per roll)	$20
Cover Roll (per roll)	$20
Leukotape (per roll)	$18
Buddy Tapes	$3
Oval 8 Ring	$18
Finger PIP Flexion Straps	$5

Other:

Heelbo Elbow Pad	$12.17 + .94 tax
Heel Lift	$5
Thermophore Heat Pad	
14 x 14	$65
14 x 27	$75
D-Core Cervical Pillow	$59
Electrodes (pack of 4)	$10
Aline Orthotics	$74.25 + 5.75 tax
TENS Unit	$48.60
EMS Unit	$80 + tax

I understand Mesa Physical Therapy’s policy regarding the issuance of therapy supplies.

Sign_____ Date_____