Notice & Consent to Treat

Patient: **Today's Date:**

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

By signing this form, you acknowledge that you have given consent to receive treatment from The Blueprint Physical Therapy regarding provided detail and knowledge of the reason for seeking out treatment.

X____

Patient/Guardian Signature Date

GENERAL CONSENTS AND ACKNOWLEDGEMENTS

1. I consent to and hereby authorize The Blueprint Physical Therapy, through its appropriate personnel, agents and affiliates to perform the evaluation, care and treatment procedures that are deemed necessary. I understand that no warranties or guarantees have been made to me about the outcome of my care.
2. I understand that The Blueprint Physical Therapy may record videos or obtain photos of my treatments to document and to be used for social media content for educational purposes, patient testimonials, or for progressions throughout treatments.
3. I understand and acknowledge that The Blueprint Physical Therapy may lease or license real estate, equipment or other personal property, I

hereby waive and release, any and all claims, demands, actions, and causes of action whatsoever arising out of or in any way related to any loss, damage, or injury, including death, that may be sustained by me and/or such Minor in, on, upon, in connection with or while making use equipment regardless of whether any such loss, damage, or injury is caused by the active or passive negligence of the Releasees or otherwise and regardless of whether any such liability arises in tort, contract, strict liability or otherwise, to the fullest extent allowed by law.. 7. I understand and consent that The Blueprint Physical Therapy may from time to time make calls and/or send text messages to any telephone number associated with my account, including wireless telephone numbers. I understand that I am not required to agree to this provision as a condition of receiving services and that my consent may be revoked at any time. 8. I understand and consent that The Blueprint Physical Therapy may send emails to me at any email address provided and/or use other electronic means of communication to the extent permitted by law. I understand that I am not required to agree to this provision as a condition of receiving services and that my consent may be revoked at any time. 9. I understand and acknowledge that my appointment times are scheduled in accordance with availability of professional staff. I understand that my appointment may be rescheduled I arrive more than 15 minutes late. I also acknowledge that The Blueprint Physical Therapy requires 24 hours' advance notice of cancellation and that The Blueprint Physical Therapy reserves the right to charge a $40.00 cancellation fee if I fail to cancel an appointment at least 24 hours in advance.

X____

Patient/Guardian Signature Date

MEDICAL HISTORY & INTAKE FORM

Name: ________________________________ **DOB:** ____ /____ /____

Phone: ____________________________ **Email:** ___________________________

How did you hear about The Blueprint Physical Therapy? ___________________________

Work Status: ☐ Employed ☐ Retired ☐ Disabled ☐ Student

Existing or Relevant Previous Conditions: Yes or No (Circle One)

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

List any drug or latex allergies you are aware of: ________________________ ☐ None

Describe any other conditions that you may have:

FALL HISTORY

Are you afraid of falling? ______

Have you fallen in the last year? _____

If yes, how many times and please describe most recent fall(s):

____

____

PHYSICAL THERAPY GOALS

____

SURGICAL HISTORY

Body Region: _____________ Surgery Type: ________________________ Date: ______________

Body Region: _____________ Surgery Type: ________________________ Date: ______________

Body Region: _____________Surgery Type: ________________________ Date: ______________

Body Region: ____________ Surgery Type: ________________________ Date: ______________

MEDICATIONS

Drug: _____________________ Reason Taking: ____________________________

Drug: _____________________ Reason Taking: ____________________________

Drug: _____________________ Reason Taking: ____________________________

Use back of this form if you are taking more than three medications.

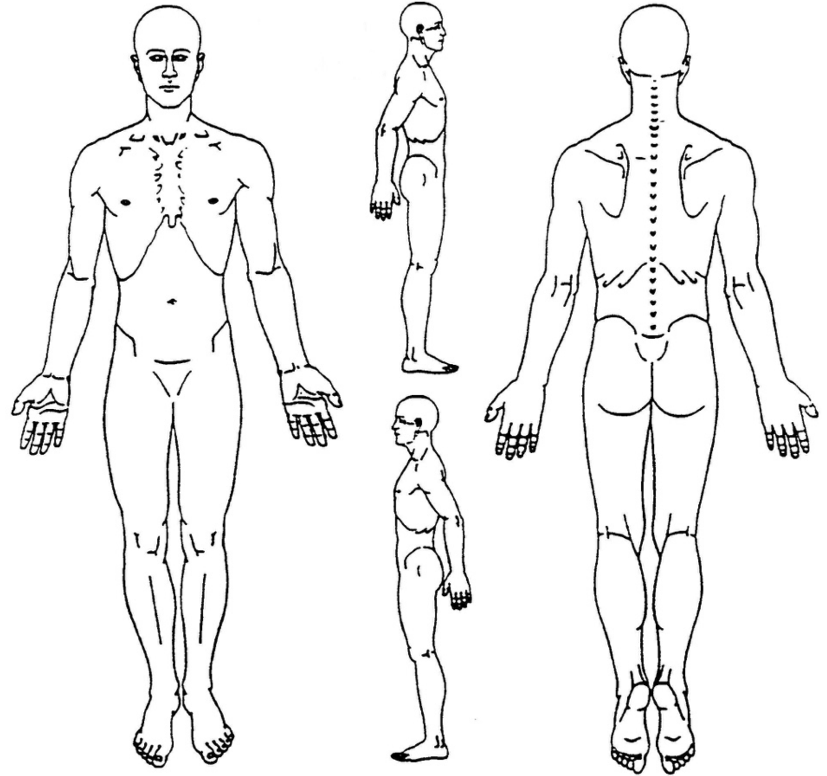
Primary Care Physician ___________________________ Phone number: __________________

Referring Provider _____________________________Phone number: ___________________

INDICATE LOCATION AND TYPE OF PAIN

Key:

Ache/Dull: x x x
Sharp/Stabbing: ^ ^ ^
Numbness/Tingling: * * *
Burning: # # #
Throbbing: < < <
Other: o o o



Mark an "X" on the lines below that best describes your response.

1. **Which activity/activities cause you the most pain/ trouble performing:**

   ____

2. **Pain at WORST**

0 **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**
No Pain Worst Pain

1. **Pain at BEST**

0 **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**
No Pain Worst Pain

Use back of this form for any additional information that was not included in the form and you feel it is important to mention.