Knewtson Health Group
Physical Therapy • Chiropractic
Personal Training • Massage • Nutrition

23505 Smithtown Road
Suite 100
Excelsior, MN 55331
952-470-8555
www.khealthgroup.com

Physical Therapy Medical History Questionnaire and Consent to Treat

Name: _____ DOB: _____ Date: _____
Referring Doctor: _____ Primary Insurance: _____
Occupation, including activities required during the day: _____
Leisure Activities/Exercise: _____
Pregnant: Y N Due Date: _____ Smoker: Y N
Do you have a pacemaker: Y N Allergies: _____
Emergency Contact (name/phone): _____ Relation: _____

Past Medical History: (check if you EVER have been told you have/had)

- □ Arthritis
- □ Head injury
- □ Ulcers
- □ Osteoporosis/osteopenia
- □ Cancer
- □ Stroke
- □ Pacemaker
- □ Depression
- □ Seizures
- □ Diabetes
- □ Digestive problems
- □ Mental illness
- □ Heart problems
- □ Lung problems
- □ Kidney disease
- □ Liver disease
- □ High blood pressure
- □ Parkinson's disease
- □ Chemical dependency
- □ Broken bones: _____
- □ Other: _____

Current Medications (prescription and non-prescription): (□ See Attached Sheet) _____
_____

Have you ever taken steroid medication for any medical condition? Yes No
Have you ever taken blood thinners or anticoagulant medication? Yes No

Since your symptoms began, have you had any of the following:

- □ Dizziness
- □ Fever/sweat/chills
- □ Loss of balance
- □ Weight changes
- □ Nausea/ vomiting
- □ Numbness/tingling/burning
- □ Numbness in genital/anal area
- □ Significant night pain
- □ Bowel/bladder changes
- □ Weakness
- □ Fatigue
- □ Recent infection
- □ Shortness of breath
- □ Chest pain
- □ Increased headaches
- □ Problems with vision/hearing/speech
- □ Other: _____

Family Medical History: (immediate family members)

- □ Cancer
- □ Heart problems
- □ High blood pressure
- □ Diabetes
- □ Blood Clots
- □ Stroke

During the past month have you 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
Is this something with which you would like help? Yes No Yes, but not today

Current Symptoms:
What do you believe started the symptoms? _____
When (approximately) did the symptoms start? _____
Are the symptoms getting: □ WORSE □ BETTER □ STAYING THE SAME
Have you received any treatment for your current symptoms? Yes No
If Yes, what and was it helpful? _____
Any surgeries, hospitalizations, or imaging (x-ray, MRI)? _____
How are you able to sleep at night? □ No problem sleeping □ Wake with pain
□ Difficulty falling asleep □ Only with medication

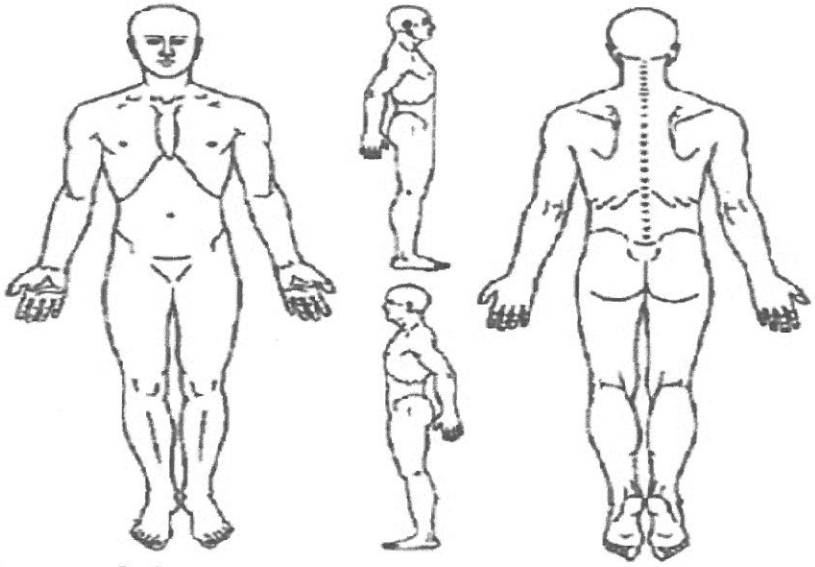
Please describe the nature of your primary complaint: _____
(i.e. pain, numbness, tingling, weakness)

Please use the scales below to describe the severity of your pain:

Worst level of pain: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

Current level of pain: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

Best level of pain: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible



Please mark the areas that you feel pain

When during the day are your symptoms better?

_____

When during the day are your symptoms worse?

_____

Aggravating Factors: Please list 3 activities that make your symptoms worse:

1. _____
2. _____
3. _____

Easing Factors: Please list 3 activities that make your symptoms better:

1. _____ 2. _____ 3. _____

What are your goals for physical therapy? _____

Consent to treat:

"By signing this form, I consent and authorize my medical health provider to assess and treat me. I understand that my provider is available to explain the purpose of treatment, and that I have the right to refuse recommended treatment. I understand I have the right to revoke this consent, in writing, at any time except where the Knewtson Health Group has already made disclosures in reliance to the consent.
I consent to treatment(s) provided by this clinic. I understand that my condition my necessitate modifications from time to time due to the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to other perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff."

Patient/Guardian Signature:_____ **Date:**_____

If Applicable, Patient's Relationship to Guardian:_____

Therapist Signature:_____ **Date:**_____

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Physical Therapy New Patient Forms

Name: _____ DOB: _____ Date: _____
Address: _____ City/State/Zip: _____
Phone Numbers (home): _____ (cell): _____
E-mail Address: _____

Financial Responsibility:
Insurance Company: _____
Policy Holder's Name: _____ Policy Holder's DOB: _____

Cancellations:
Cancellations must be made 24 hours in advance, or there is a $75.00 fee assessed to you, not your insurance company, regardless of MVA or Workman's Comp status. This fee also applies to any missed appointments in which the patient fails to appear at the scheduled time of the appointment.

I acknowledge the cancellation policy and will adhere to this policy.

Patient/Guardian Signature: _____ Date: _____

Credit Policy & Patient Responsibility
Thank you for choosing Knewtson Health Group as your health care provider. We are committed to your treatment being successful. Please understand that prompt payment of your bill is considered part of your treatment. We have put together the details of our credit & financial policies below. Please read carefully and sign below to begin treatment. All patients complete our information and insurance forms.

Full payment is due at date of service. For your convenience, we accept cash, check, Visa/Discover. We offer payment plans with prior credit approval and signed agreements. A finance charge of 18% annually (1.5 per month) will begin accruing after 60 days from the date of service.

Patients with insurance coverage
We may accept assignment of insurance benefits after your second visit. However, we do require your co-payment be paid at the time of service. The balance incurred is your personal responsibility whether your insurance company pays or not. Coverage amounts vary from policy to policy. You understand that your insurance policy is a contract between you and your insurance company. This office holds no party to that contract and will not be held responsibly in the event that your insurance company denies any claim.

Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for payment, regardless of what your insurance company's arbitrary discrimination of usual and customary rates.

In the event that your account becomes past due and is referred to an outside collection agency or attorney, you will be responsible for the collection costs (up to 33% of the balance due), along with reasonable attorney fees and court costs incurred by this office.

Patient Name: _____
Patient/Guardian Signature: _____ Date: _____
If applicable, patient's relationship to guardian: _____

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Patient Consent and Financial Responsibility

In an effort to create open communication with our patients, we would like to inform you of our office fees up front. These fees may be reduced as a result of your personal insurance. Lease note that the difference in prices between Physical Therapy and Chiropractic are due to the fact that the Physical Therapist works with you for thirty minutes to an hour. The Physical Therapist also develops exercises specific to your individual body type and rehabilitation needs.

Prices are subject to your insurance benefits, and your actual patient responsibility may vary from the cash plan prices. We strongly advise you to call your insurance company to verify your eligibility and coverage, or to ask any questions that you may have about your policy. Remember all policies are not the same, and therefore we cannot give a generalization of benefits.

Please read and sign the form below. Ask questions if there is something you do not understand.

Please check to indicate approval:

____ **Release of medical records for my medical care or as required by law:**
-To health care providers directly involved in my care.
-To State, Federal, and accrediting bodies for required reporting data and/or surveys for compliance
-For purposes of my care and for business operations
NOTE: records are not automatically sent to your physician. They must be requested.

____ **Assignment of benefits/bill my insurance:**
-I authorize Knewtson Health Group to send my bills for my medical care and treatment to my insurance company and/or Medicare or Medicaid for payment, to the extent my insurance company and/or Medicare/Medicaid is required to pay the bill under terms of my insurance policy or by law.
-I request that my insurance company and/or Medicare/Medicaid pay Knewtson health Group and the providers who are involved in my treatment.
-I consent to the release of my medical records by Knewtson Health Group to my insurance company and/or Medicare/Medicaid (and organizations working on their behalf) if necessary in order for my bills to be paid.
-I agree to pay for charges not covered by my insurance.
-I understand that if I do not check this box Knewtson Health Group will send a bill directly to me for payment

____ **Release of medical records for medical or scientific research:**
-I agree that my records may be used by Knewtson Health Group for medical or scientific study.
-No information which can identify me as a patient or participant in any such study will be shared.
-I may revoke this in writing at any time.

____ **I acknowledge that I have been offered a copy of Knewtson Health Group's Privacy Practice Information. If I would like a copy of this in the future, I will ask for one.**

Patient Name: _____
Patient/Guardian Signature: _____ Date: _____
If applicable, patient's relationship to guardian: _____