move easy
PHYSICAL THERAPY

Today's Date:_____

PATIENT INFORMATION

Name: _____
First Last MI

Male Female Date of Birth: ____/____/____ Marital Status: Single Married Divorced Widowed

Address:_____
Street Address City State Zip Code

Email Address: _____

Would you like to receive appointment reminders by email? Yes, Notify me by email. No, Do not email me.

Home Phone: (_____) _____-_____ Work or Cell Phone (_____) _____-_____

Would you like to receive appointment reminders via text message? Yes, Notify me by text. No, Do not text me.

DL #:_____ State Issued:_____ Please provide a copy for our records.

Occupation: _____Employer: _____

Emergency Contact: _____Ph: (_____)_____-_____ Relationship to Patient: _____

Who referred you to this office? : _____

MEDICAL INFORMATION

Reason for being seen: _____

Date of Current Injury or Onset:_____Is it related to Work O Yes O No
Auto Accident O Yes O No

Other? Please Explain: _____

PHYSICIAN INFORMATION

Referring Physician:_____Ph: (____)_____-_____

Office Address: _____
Street Address City State Zip Code

Deena Levy MA, PT
2301 Grant Street, Berkeley, CA 94703
510.540.7816 deena@moveeasypt.com www.moveeasypt.com

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APPOINTMENT POLICY

I understand and agree that Move Easy Physical Therapy requires 24-houradvance notice of cancellation. If I fail to give 24-hour notice of cancellation or fail to show up for an appointment, I may be subject to a $100 charge (which is not covered by insurance).

Signature: _____ Date: _____

(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient: MOTHER FATHER LEGAL GUARDIAN

AUTHORIZATION FOR TREATMENT

I hereby consent to and authorize all therapy treatments, which in conjunction with the judgment of my attending physician may be considered necessary and/or advisable for the diagnosis and/or treatment of the patient named above at Move Easy Physical Therapy.

Signature: _____ Date: _____

(Parent or Legal Guardian must sign if patient is under18 years of age)

Relationship to Patient: MOTHER FATHER LEGAL GUARDIAN

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Move Easy Physical Therapy reserves the right to modify the privacy practices outlined in the notice. I have received a copy of the Notice of Privacy Practices for Move Easy Physical Therapy

- ☐ Patient agrees to release of medical or other information to process claim
- ☐ Patient agrees to accept assignment of payment
- ☐ Patient gives office the permission to leave a message on answering machine
- ☐ Patient gives permission to discuss their medical condition with other health Care practitioners and family members involved in their care
- ☐ Patient gives permission to discuss their medical condition with (please list): _____

NAME OF PATIENT: _____

(Please Print)

SIGNATURE OF PATIENT: _____ Date: _____

(Parent or Legal Guardian must sign if patient is under 18 years of age)

RELATIONSHIP TO PATIENT: SELF MOTHER FATHER LEGAL GUARDIAN

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PATIENT NAME: _____DATE: _____

FINANCIAL POLICY AND INSURANCE INFORMATION

I understand and agree that Move Easy Physical Therapy (MEPT) will submit insurance claim forms to my insurance company as a matter of convenience only, and that I am responsible for all charges regardless of my existing medical coverage. I understand that I am responsible for all supplies, such as braces or exercise equipment, which I am provided during treatment. I understand that I will pay for supplies upon receipt.

I hereby give authorization for payment of insurance benefits to be made directly to MEPT for services rendered. In the event that my insurance company forwards payment directly to me, instead of MEPT, I will immediately deliver said payment to MEPT.

I understand and agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due, upon demand. I understand and agree that if it becomes necessary for MEPT to utilize an outside collection agency or to commence court action, for the collection of any outstanding charges, I will be responsible for the outstanding balance (plus a $35 processing fee), and in addition, attorney fees, court costs and other expenses of litigation.

Signature of Person Responsible for Charges: _____ Date: _____
(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient, **if patient is under 18 years of age**: Mother Father Legal Guardian

PRIMARY INSURANCE

Name of Subscriber: _____ Birthdate: _____/____/_____

Relationship to Patient: Self Spouse Parent Other: _____

Address of Subscriber: _____
(If Different than Patient) Street Address City State Zip Code

Phone #'s: (_____) _____-_____ (_____) _____-_____ SS #:_____-____-_____
(If Different than Patient) Home Phone Cell Phone

Insurance Co: _____ Phone: (_____) _____-_____

Subscriber #: _____ Group #/Name: _____

Subscriber's Employer: _____Phone:(_____) _____-_____

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PATIENT NAME: _____ DATE: _____

MEDICAL HISTORY (Please check and circle any applicable condition)

Allergies	O Yes O No	Dizzy Spells	O Yes O No	MRSA	O Yes O No
Anemia	O Yes O No	Emphysema/Bronchitis	O Yes O No	Multiple Sclerosis	O Yes O No
Anxiety	O Yes O No	Fibromyalgia	O Yes O No	Muscular Disease	O Yes O No
Arthritis	O Yes O No	Fractures	O Yes O No	Osteoporosis	O Yes O No
Asthma	O Yes O No	Gallbladder Problems	O Yes O No	Parkinsons	O Yes O No
Auto Immune Disorder	O Yes O No	Headaches	O Yes O No	Rheumatoid Arthritis	O Yes O No
Cancer	O Yes O No	Hearing Impairment	O Yes O No	Seizures	O Yes O No
Cardiac Conditions	O Yes O No	Hepatitis	O Yes O No	Smoking	O Yes O No
Cardiac Pacemaker	O Yes O No	High Cholesterol	O Yes O No	Speech Problems	O Yes O No
Chemical Dependency	O Yes O No	High/Low Blood Pressure	O Yes O No	Strokes	O Yes O No
Circulation Problems	O Yes O No	HIV/ AIDS	O Yes O No	Thyroid Disease	O Yes O No
Currently Pregnant	O Yes O No	Incontinence	O Yes O No	Tuberculosis	O Yes O No
Depression	O Yes O No	Kidney Problems	O Yes O No	Vision Problems	O Yes O No
Diabetes	O Yes O No	Metal Implants	O Yes O No		

If "Yes" to any of the above, please explain and give approximate dates.
Please describe any other relevant conditions.

Fall History
Injury as a result of a fall in the past year? O Yes O No Date of Fall: _____

Two or more falls in the last year? O Yes O No Dates of Falls: _____

Surgical History

Body Region: _____ Surgery Type: _____Date of Surgery:_____
Body Region: _____ Surgery Type: _____Date of Surgery:_____
Body Region: _____ Surgery Type: _____Date of Surgery:_____
Body Region: _____ Surgery Type: _____Date of Surgery:_____

Current Medications

Drug: _____ Dosage: _____ Reason for Taking:_____
Drug: _____ Dosage: _____ Reason for Taking:_____
Drug: _____ Dosage: _____ Reason for Taking:_____
Drug: _____ Dosage: _____ Reason for Taking:_____
Drug: _____ Dosage: _____ Reason for Taking:_____

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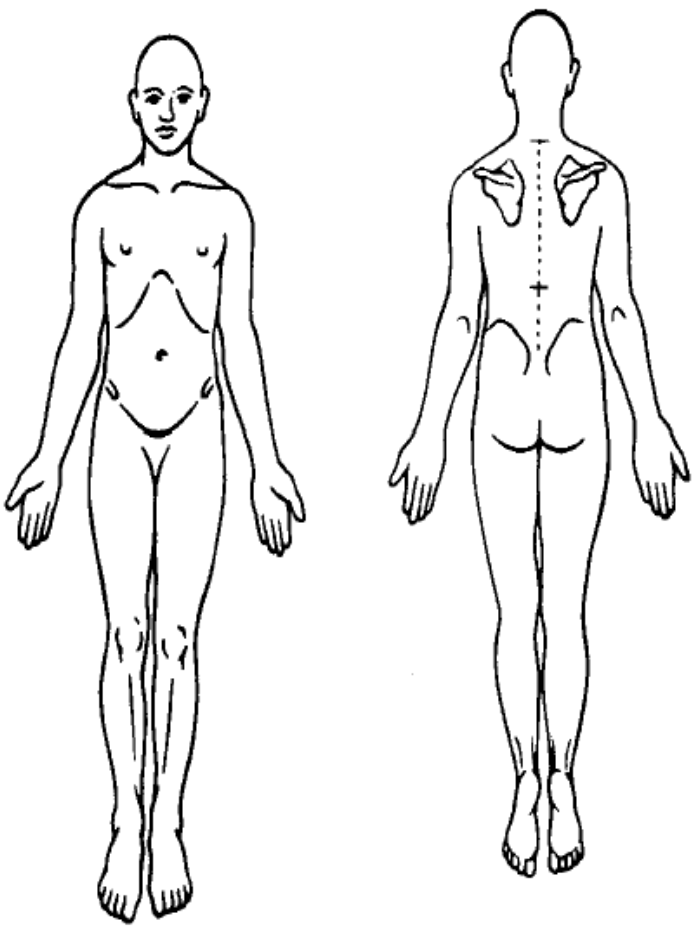
PATIENT NAME: _____ DATE: _____

Graphic Pain Assessment

PAIN INTENSITY SCALE		PAIN LOCATION BODY DIAGRAMS
10	Pain as bad as it could be	
9	Excruciating	
8		
7	Severe	
6		
5	Moderate	
4		
3	Mild	
2	Slight	
1		
0	No Pain	

- Circle on the diagram where you are currently experiencing pain and or symptoms. Please use the intensity scale to label your symptoms.
- Please label any other areas where you may be experiencing tingling or numbness.

Please describe the details of your injury, including the date of injury and any treatment of the injury:
Overall are your symptoms improving or getting worse?

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