



**PATIENT HEALTH HISTORY INFORMATION -PLEASE PRINT CLEARLY**

**Name** \_\_\_\_\_ **Preferred Name/Nickname** \_\_\_\_\_  
**Birth Sex**  Male  Female (required for Insurance) **Birth Date** \_\_\_\_\_  
**Preferred Pronoun** \_\_\_\_\_ **Language**  English  Other \_\_\_\_\_  
**Home Address** \_\_\_\_\_ **Apt/Unit** \_\_\_\_\_  
**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**Email Address (Correspondence and E-statements)** \_\_\_\_\_  
**Cell Phone** \_\_\_\_\_ **Home Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_

**Resides at**  Home  Residential Care Facility \_\_\_\_\_  
 Intermediate Care Facility \_\_\_\_\_  
Do you have an ID WAIVER?  Yes  No If yes, please see Front Desk Staff  
**Do you have Medicare?**  Yes  No **If yes are you receiving home health services?**  Yes  No

**Preferred method of contact**  Cell  Home  Work **May we leave a message?**  Yes  No  
**Would you like to receive text or email appointment reminders**  Text  Email  No Thanks

**Emergency Contact**  
**Name** \_\_\_\_\_ **Relation** \_\_\_\_\_  
**Address** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Please let the Front Desk Staff know if there are any Holiday's you or your family do not celebrate.**

**EMS CONSENT:**

**Please specify below by checking ONE box only:** I request Unified Therapy Health Services to:  
 PROVIDE (RESUSCITATE REQUESTED) rescue breathing or CPR if I am in their care during a time of crisis  
 DECLINE (DO NOT RESUSCITATE) or use rescue breathing or CPR if I am in their care during a time of crisis.

**REASON FOR VISIT**

Back Pain  Neck Pain  Shoulder/Arm Problems  Hand Problems  
 Leg/Foot Problems  Balance Problems  Other

**Date condition began** \_\_\_\_\_ **Date of next doctor appointment for this condition** \_\_\_\_\_  
**Date of Surgery (if applicable)** \_\_\_\_\_ **Type of surgery** \_\_\_\_\_  
**Referring Doctor** \_\_\_\_\_ **Phone Number of Referring Doctor** \_\_\_\_\_

**Have you EVER been diagnosed with any of the following conditions:**

<input type="checkbox"/> Y <input type="checkbox"/> N	Angina	<input type="checkbox"/> Y <input type="checkbox"/> N	Depression	<input type="checkbox"/> Y <input type="checkbox"/> N	Joint pain
<input type="checkbox"/> Y <input type="checkbox"/> N	Anxiety	<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes Type I	<input type="checkbox"/> Y <input type="checkbox"/> N	Lymphedema
<input type="checkbox"/> Y <input type="checkbox"/> N	Arrythmia	<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes Type II	<input type="checkbox"/> Y <input type="checkbox"/> N	Migraine Headaches
<input type="checkbox"/> Y <input type="checkbox"/> N	Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	Fibromyalgia	<input type="checkbox"/> Y <input type="checkbox"/> N	MRSA
<input type="checkbox"/> Y <input type="checkbox"/> N	Blood Clotting Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Frequent UTI	<input type="checkbox"/> Y <input type="checkbox"/> N	PVD
<input type="checkbox"/> Y <input type="checkbox"/> N	Bowel Incontinence	<input type="checkbox"/> Y <input type="checkbox"/> N	GERD	<input type="checkbox"/> Y <input type="checkbox"/> N	Multiple Sclerosis
<input type="checkbox"/> Y <input type="checkbox"/> N	Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N	MI/Heart Attack
<input type="checkbox"/> Y <input type="checkbox"/> N	Carpal Tunnel Syndrome	<input type="checkbox"/> Y <input type="checkbox"/> N	DVT	<input type="checkbox"/> Y <input type="checkbox"/> N	Osteoarthritis
<input type="checkbox"/> Y <input type="checkbox"/> N	Cellulitis	<input type="checkbox"/> Y <input type="checkbox"/> N	High Cholesterol	<input type="checkbox"/> Y <input type="checkbox"/> N	Osteoporosis
<input type="checkbox"/> Y <input type="checkbox"/> N	Chronic Back Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Gout	<input type="checkbox"/> Y <input type="checkbox"/> N	Psoriatic Arthritis
<input type="checkbox"/> Y <input type="checkbox"/> N	Chronic Neck Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatoid Arthritis
<input type="checkbox"/> Y <input type="checkbox"/> N	Chrones's Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis B	<input type="checkbox"/> Y <input type="checkbox"/> N	Scoliosis
<input type="checkbox"/> Y <input type="checkbox"/> N	Degenerartive Disc Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis C	<input type="checkbox"/> Y <input type="checkbox"/> N	Seizure Disorder
<input type="checkbox"/> Y <input type="checkbox"/> N	Close Head Injury	<input type="checkbox"/> Y <input type="checkbox"/> N	Hiatal Hernia	<input type="checkbox"/> Y <input type="checkbox"/> N	Shortness of Breath
<input type="checkbox"/> Y <input type="checkbox"/> N	Colitis	<input type="checkbox"/> Y <input type="checkbox"/> N	HIV/AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N	Sleeping Disorder
<input type="checkbox"/> Y <input type="checkbox"/> N	Congestive Heart Failure	<input type="checkbox"/> Y <input type="checkbox"/> N	Hypertension	<input type="checkbox"/> Y <input type="checkbox"/> N	TB
<input type="checkbox"/> Y <input type="checkbox"/> N	COPD	<input type="checkbox"/> Y <input type="checkbox"/> N	Hypothyroidism	<input type="checkbox"/> Y <input type="checkbox"/> N	Do you Smoke
<input type="checkbox"/> Y <input type="checkbox"/> N	CVA (Stroke)	<input type="checkbox"/> Y <input type="checkbox"/> N	IBS		
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> During the Past Month have you been feeling down, depressed or hopeless?					
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> During the Past Month have you been bothered by having little interest or pleasure in doing things?					
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If yes to either, is this something with which you would like more resources from UTHS?					
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way?					
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> FOR WOMEN: Are you currently pregnant or do you think you might be pregnant?					

Do you have a pace maker, transplanted organ, joint replacement, or other metal implants?  Yes  No

Explain \_\_\_\_\_

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

---



---



---

Please list any special tests performed for this problem (x-ray, MRI, labs, etc)

---



---



---

**CURRENT MEDICAL CARE:**

Please check any of the following whose care you have been under in the past 3 months:

- Physician (MD, DO)       Podiatrist (DPM)       Psychiatrist/Psychologist/Dentist
- Physical Therapist       Chiropractor (DC)       Other: \_\_\_\_\_

If you have seen any of the above professionals during the last 3 months, please describe the reason (illness, medical, routine visit,etc)

---



---



---

**ALLERGIES:**

**Allergies:** Please list any medications you are allergic to: \_\_\_\_\_

Any other allergies? \_\_\_\_\_ Are you latex sensitive?     Yes     No

---

**MEDICATIONS:**

Please list any medications including pills, injections, and/or skin patches, etc you are currently taking.

(You may choose to provide a medication list to our Front Desk Staff to scan into your medical history, if easier)

---



---



---

**\*\*Please note that ALL sharps must be disposed of at home- NO SHARPS CONTAINER AT UNIFIED THERAPY!**

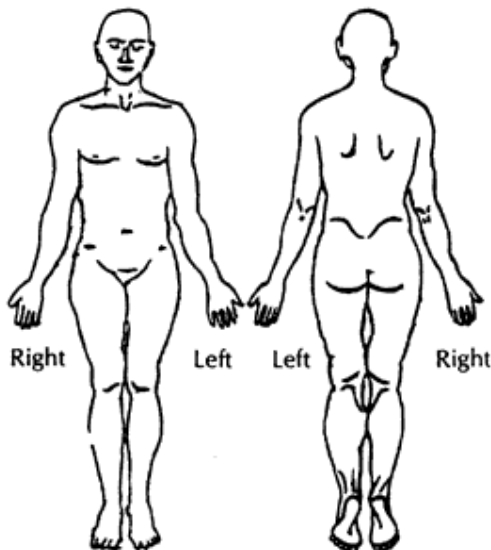
Have you ever taken steroid medications for any medical conditions?     YES     NO

If Yes, please explain \_\_\_\_\_

Have you ever taken blood thinning or anticoagulant medications for any medical conditions?     YES     NO

---

**Body Chart**



**Please mark the body chart where your current symptoms are located**

**My symptoms currently:**

- Come and go
- Are constant
- Are constant, but change with activity

Using the 0 to 10 pain scale, with 0 being “no pain” and 10 being the worst pain imaginable please describe:

Choose your **current level of pain** while completing this survey: 0 1 2 3 4 5 6 7 8 9 10

Choose the **least amount of pain** you have had in the past 24 hours: 0 1 2 3 4 5 6 7 8 9 10

Choose the **worst your pain** has been in the past 24 hours: 0 1 2 3 4 5 6 7 8 9 10

Please list 3 activities that you are unable to do or have moderate to extreme difficulty doing as a result of you injury or pain level. For each activity you list, rate the level of difficulty you have performing the activity on the 0-10 scale.

0 = unable to perform activity

10= able to perform activity at the same level as before injury/pain

Activity #1 \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10

Activity #2 \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10

Activity #3 \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10

How are you currently able to sleep at night due to your symptoms?

- No problem sleeping       Difficulty sleeping       Awakened by pain       Sleep only with medication

When are your symptoms **worst**?     Morning     Afternoon     Evening     Night     After Activity

When are your symptoms the **best**?     Morning     Afternoon     Evening     Night     After Activity

---

### BILLING/FINANCIAL

**Please provide the front desk staff with all insurance cards.**

### INFORMATION RELEASE FORM:

I hereby give Unified Therapy Services permission to receive and release all information to/from the following individuals/groups/organizations during my care at Unified Therapy Services.

Physician \_\_\_\_\_

Medical Vendors \_\_\_\_\_

Insurance Company \_\_\_\_\_

Spouse/Partner/Parent \_\_\_\_\_

School/Employer \_\_\_\_\_

Other \_\_\_\_\_

## MARKETING

Please tell us how you learned of our services or whom we may thank: \_\_\_\_\_

Upon discharge, may we send follow up postcards to your mailing address?:  Yes  No

## PUBLIC RELEASE

Occasionally, Unified Therapy Services will photograph or videotape for educational and/or marketing purposes. We will always verbally discuss with the patient/parents/guardians before anything is printed for marketing purposes.

I **ALLOW** photos/videos to be taken.

I **DECLINE** the use of photos/videos to be taken.

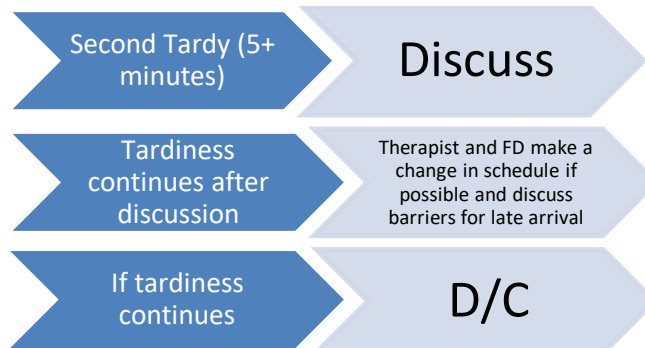
\*I hereby **give my permission** to use \_\_\_\_\_'s first name and last initial to be used by **Unified Therapy Services** to identify accomplishments, birthdays, artwork, etc.

## UNIFIED THERAPY SERVICES ADULT PATIENT ATTENDANCE POLICY

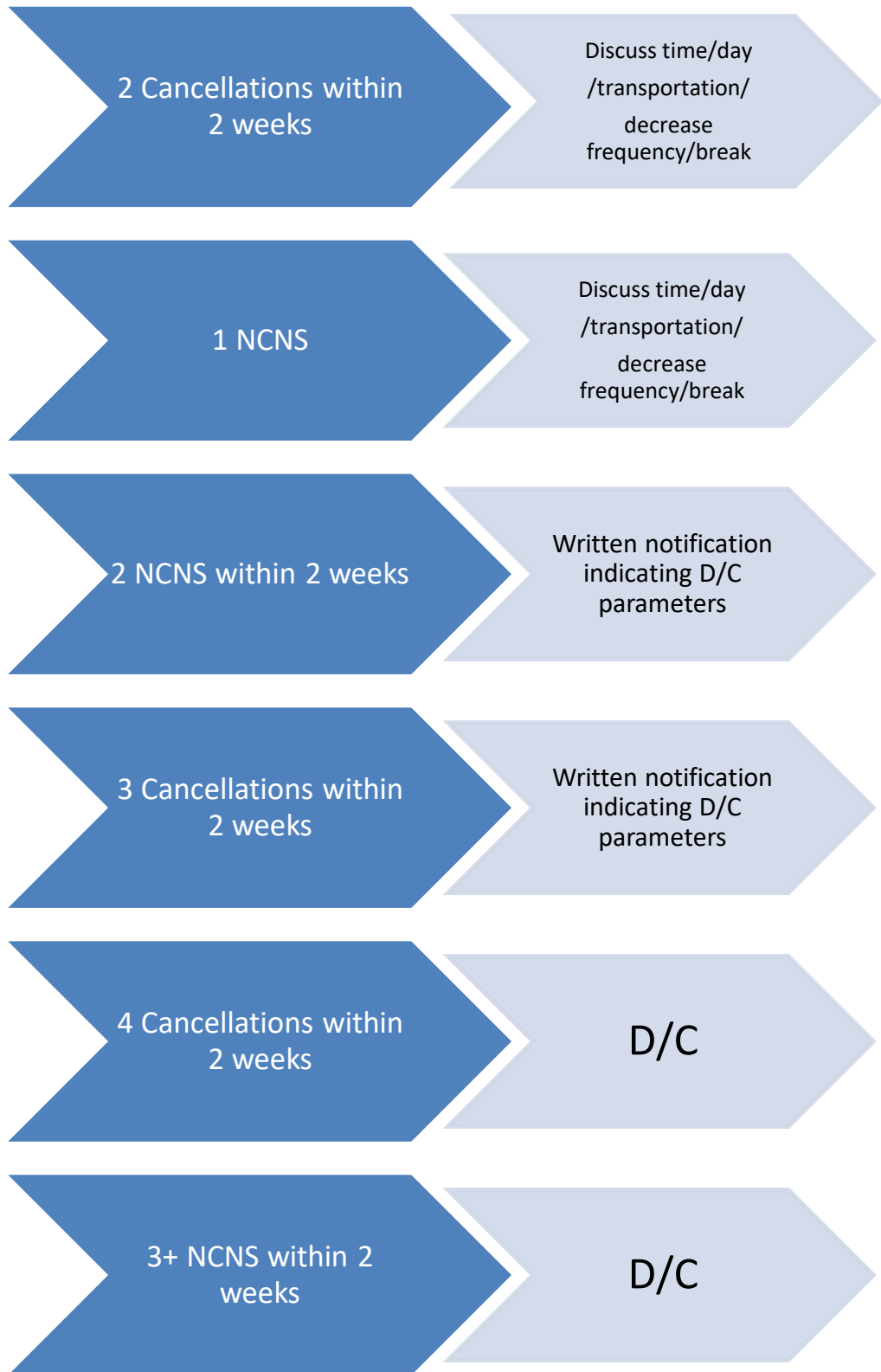
I understand that it is my responsibility to attend all scheduled therapy appointments or to *call and cancel at least 2 hours in advance*. Messages may be left after hours and will be received the next business day.

- I understand that if I don't attend the scheduled appointments and the staff of UTS must call me, this will be considered a **No Call/No Show (NC/NS)** visit.
- I understand that I may be discharged from Aqua Therapy if I have a combination of 2 NC/NS or cancellations.
- I understand there may be extended excused absences related to hospitalizations, surgery, injuries, illness, and extended vacations.
- I understand my employer will receive attendance reports if payment for therapy is via worker's compensation.
- I understand that transportation information is available.
- I understand any exclusion will be at the discretion of Unified Therapy Services.
- I understand that I may see different therapists for my sessions.

## ARRIVAL TARDINESS



**ATTENDANCE GUIDELINES**



I have read & understand the above mentioned Attendance Policy \_\_\_\_\_(initials)

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow –up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand you *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

---

## CONSENT FOR CARE/ASSIGNMENT OF BENEFITS/LIABILITY WAIVER

I certify that the above noted insurance carriers or payment sources are complete and correct as written.

I authorize Unified Therapy Services to release information from my medical records as may be necessary for the completion of the clinic’s claims for reimbursement to third party payers as needed for this or related claims. This authorization may include copies of my medical records to be sent to my insurance carrier.

In consideration of the services received or to be received by Unified Therapy services, I assign all insurance, Medicare, or Medicaid due me to Unified Therapy Services. I hereby agree to pay Unified Therapy Services any and all charges that exceed or that are not covered by my insurance coverage.

I willingly agree to comply with the stated and customary terms and conditions for participation in therapy services and other clinic operations including protection against and possible exposure to/illness from infectious diseases and I knowingly and freely assume all such risks.

I, for myself, assigns, personal representative and next of kin, hereby release, defend and hold harmless Unified Therapy Services and their employees used to conduct therapy services and clinic operations (“releases”), with respect to any and all illness, disability, death, or loss or damage to person or property arising out of participation in therapy services or clinic operations, whether arising from the negligence of releases or otherwise, to the fullest extent permitted by law.

I APPROVE OF THE NOTED DIAGNOSTIC/REHABILITATIVE SERVICES.

**Authorized Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**By signing above, I certify that the previous pages of the new patient paperwork information are true and accurate to the best of my knowledge.**