KINETIC DYNAMICS PHYSICAL THERAPY

PATIENT INFORMATION

Name _____ Date of Birth _____ Age _____
Email _____
Phone: Mobile (____) ____ - _____ Work (____) ____ - _____ Home (____) ____ - _____
Address _____
City _____ State _____ Zip _____
Preferred Method of Contact: ☐ email / phone: ☐ mobile ☐ work ☐ home
Referred by _____
Occupation/Sport _____

PARENT/GUARDIAN INFORMATION ☐ N/A

Name _____ Relationship to Patient _____
Phone: (____) ____ - _____ Email _____
Address _____ City _____ State _____ Zip _____
Parental Consent for Treatment : As parent and/or legal guardian of _____,
I authorize Kerri Demitrovic, MPT, MDT to treat while I am not present.
Parent/Guardian Signature: _____ Date _____

EMERGENCY CONTACT

Name _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
Phone: (____) _____ - _____ Email _____

CURRENT INJURY HISTORY

What issue(s) are you coming to PT for? _____
When did the injury or symptoms first appear? _____
How did the injury/symptoms occur? _____
_____
What are your current symptoms (pain/burning/numbness ache) and where are they on your Body? _____
Please list your level of pain using a scale of 0 – 10 (0= no pain, 10= unbearable pain)
Current ____ /10 At its worst ____ / 10 At its best ____ /10
Did you have x-rays/MRI/CT scan of this body part? If yes, please indicate findings
_____
Have you had surgery for this condition? ☐ Yes ☐ No If yes when? _____

Patient's Signature: _____ Date _____/_____/_____
Parent / Guardian Signature (if applicable): _____Date _____/_____/_____

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GENERAL HEALTH HISTORY

To ensure that you receive a thorough and complete evaluation, please provide us with important background information on this form. If you are unclear regarding any of these questions, please leave it blank and your therapist will assist you.

Do you currently have or have you ever had any of the following?

Are you pregnant?	□ N/A □ yes □ no	Headaches	□ yes □ no
Diabetes	□ yes □ no	Fevers/chills/sweats	□ yes □ no
High Blood Pressure	□ yes □ no	Unexplained weight △	□ yes □ no
Heart Disease	□ yes □ no	Malaise (feeling unwell)	□ yes □ no
Heart Attack/ Pacemaker	□ yes □ no	Unusual fatigue	□ yes □ no
Kidney Problems	□ yes □ no	Nausea/Vomiting	□ yes □ no
Cancer	□ yes □ no	Numbness/tingling	□ yes □ no
Osteoporosis	□ yes □ no	Unexplained weakness	□ yes □ no
Asthma/Breathing Difficulties	□ yes □ no	Dizziness/light headedness	□ yes □ no
Liver/Gallbladder Problems	□ yes □ no	Fainting	□ yes □ no
Hernia	□ yes □ no	Difficulty breathing/SOB	□ yes □ no
Seizures	□ yes □ no	Chest pain/palpitations	□ yes □ no
Metal Implants	□ yes □ no	Swelling in feet or hands	□ yes □ no
Recent Fractures	□ yes □ no	Difficulty with swallowing	□ yes □ no
Surgeries	□ yes □ no	Unexplained △ in appetite	□ yes □ no
Rheumatoid Arthritis	□ yes □ no	Unexplained bowel/bladder	
Stroke/CVA	□ yes □ no	changes	□ yes □ no
Hypoglycemia	□ yes □ no		

If yes to any of the above, please briefly explain and provide approximate date

_____

_____

Do you have any other medical issues or previous medical conditions not mentioned above?

_____

_____

Please list your current medications _____

_____

Patient's Name _____

Patient's Signature _____ Date _____/_____/_____

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OFFICE POLICIES

Patient/Responsible Party Name: _____

Consent to Treatment

_____ (initial) I give my consent for Kerri Demitrovic, MPT, to treat my condition within the scope of practice defined by the American Physical Therapy Association, and to provide physical therapy care and treatment considered necessary and proper in evaluating and treating my physical condition. I understand that this consent is intended as a waiver of liability for such treatment excepting acts of negligence.

Notice of Privacy & Electronic Communication Policies

_____ (initial) I hereby authorize Kerri Demitrovic, MPT, having treated me, to release to government agencies, insurance carriers, and all others who are financially liable for my care, all information needed to substantiate payments for care and to permit representatives thereof to examine and make copies of all records related to such care and treatment. I understand that if at any point my insurance coverage changes, I am to notify the staff prior to my next visit. Failure to do so will result in my being responsible for the full amount of services.

Payment for Services

_____ (initial) I understand that KD Physical Therapy, PLLC is a fee-for-service clinic. Payment of all fees is expected at the time of service. We will assist you in submitting claims to your insurance carrier. However, you are still responsible for any deductible, co-insurance/co-payments or claim denied by your insurance carrier. I authorize all payment of medical benefits directly to KD Physical Therapy, PLLC. for the services rendered. I agree to be responsible for all deductible and copayment fees.

Cancellation/No Show Policy

_____ (initial) I understand that there is a 24 hour cancellation policy and that I will be charged in full for all appointments that are not cancelled 24 hours in advance of the scheduled appointment time.

I also understand that I will be charged in full if I fail to show up for my scheduled appointment as well.

Notice of Privacy Practices for Protected Health Information.

Health Insurance Portability & Accountability Act of 1996 (HIPAA)

Due to increased awareness of the need for more strict guidelines regarding privacy of your PHI, the Health Insurance Portability & Accountability Act of 1996 (HIPAA) was legislated, effective April 14, 2003. As part of this law, Kerri Demitrovic, MPT is required to provide you with the option of receiving a copy of this notice.

_____ (initial) I am aware that this notice is available to me online at the clinic's website, www.physicaltherapykd.com, and I choose to receive such notice electronically or I have requested to receive a paper copy of the above. I understand that it is my responsibility to read and be aware of these rights as outlined in the Notice.

I have read, understand, and agree to all the above terms

_____ _____

Signature of patient or authorized representative Date