Whitefish Therapy & Sport Center

Patient Information Form

Patient Information

Last Name _____ First Name _____ MI _____ SSN _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Gender _____ Marital Status _____ Email _____

Emergency Contact

Last Name _____ Relationship _____

First Name _____ Phone _____

Employer

Name _____ Phone _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Problem

Problem Description _____ Date of Injury _____ Last Physician Visit / /

Referred By _____ Primary Care Physician _____

Latest Referral Information _____ Motor Vehicle Accident _____

Latest Plan of Care _____ That occurred in: _____

Notes: _____

Primary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Secondary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. Contact Ashley McGuire @ 406-862-9378.

(You have the right to refuse to sign this acknowledgement if you so choose.)

Signature: _____ Date: _____

MEDICAL INFORMATION

Name: _____ Date:_____

A. PLEASE READ AND ANSWER THE FOLLOWING QUESTIONS:

1. What brings you to therapy?_____

2. Are you currently engaging in any form of exercise? YES NO If yes, list activity, frequency and intensity:

_____

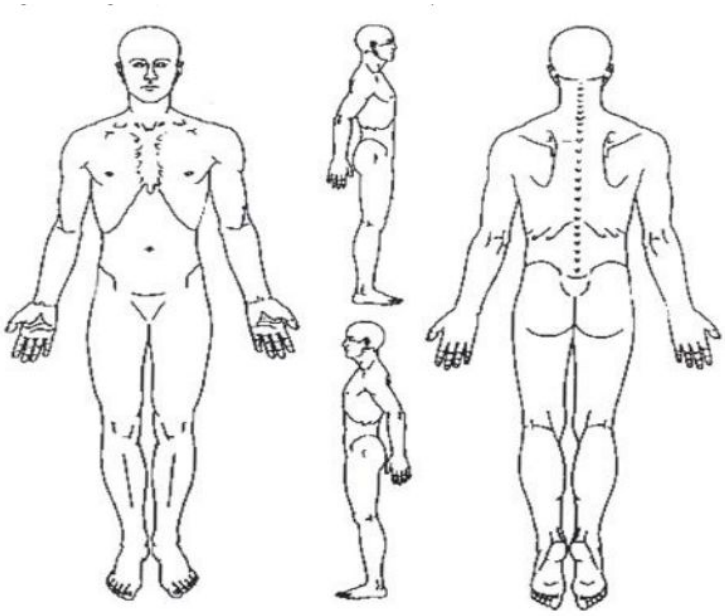
3. How active is your lifestyle? _____ Sedentary____ Moderate_____ Heavy_____

4. What is your job title if you are currently working? _____
Describe the types of activities you do for your job? (Heavy lifting, stair climbing, walking, sitting at a desk, ETC):

5. Please indicate your goals and expectations for your treatment: _____

B. PLEASE MARK WHERE YOU ARE FEELING THE PAIN ON THE DIAGRAM BELOW.

Key: /// Stabbing XXX Burning 000 Pins & Needles === Numbness



C. PLEASE RATE YOUR PAIN LEVELS

PAIN SCALE (please fill out below): 0 = no pain 10 = been to the ER for the same pain

AT WORST: 0 1 2 3 4 5 6 7 8 9 10 **CURRENT:** 0 1 2 3 4 5 6 7 8 9 10 **AT BEST**: 0 1 2 3 4 5 6 7 8 9 10

PATIENT SIGNATURE: _____

DATE: _____

MEDICAL INFORMATION

NAME: _____ DATE: _____

MEDICAL HISTORY: CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

_____ Alzheimer's _____ High blood pressure _____ Osteoarthritis
_____ Cardiovascular Disease _____ History of cancer _____ Parkinson's
_____ Current infection _____ Pregnancy _____ CVA/Stroke
_____ Lupus _____ Diabetes Type1/Type2 _____ TBI
_____ Fibromyalgia _____ HIV, HEP B, HEP C _____ Implants (medical or cosmetic)
_____Rheumatoid Arthritis _____ Previous fractured bones and/or previous surgery (if so, please note):

PLEASE LIST BELOW *(or provide a copy of)* YOUR CURRENT PRESCRIPTION/VITAMINS/SUPPLEMENTS:

Medication/Vit/Supplement	Dosage	Frequency	Route (ex: Orally)

Any falls in the last 12 months? YES NO If yes, how many? _____

Did any fall result in an injury? YES NO If yes, what injury? _____

Any recent hospitalizations? YES NO If yes, what for? _____

Have you completed a medical physical in the last year? _____

Are you currently receiving therapy services elsewhere? _____

Are you currently receiving Home Health? _____

By signing, you consent to therapy services provided by Whitefish Therapy & Sport Center.

This may include physical therapy, training services, occupational therapy, and/or speech therapy.

Services may entail the use of modalities such as therapeutic Ultrasound, E-stim, TENS, & Dry Needling. Your therapist(s) will discuss the rationale for use and will obtain verbal consent prior to treatment.

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____

Do you have any implants? YES or NO

If YES, what type? Medical Cosmetic

Do you have any blood borne pathogens? (HIV, Hepatitis, etc.) **YES** or **NO**

If YES, please list.

Would you like to receive appointment reminders the day before your appt? **YES** or **NO**

If YES, choose one: **TEXT** or **EMAIL**

If TEXT requested, who is your cell service provider? (i.e. Verizon, AT&T, Cricket, etc)

_____

If EMAIL requested, please provide email address here:

_____

IF PATIENT IS A MINOR

Guardian's Name: _____

Mailing Address: _____

City _____ State _____ ZIP _____

Phone: _____

IF INSURANCE IS IN GUARDIAN'S NAME, PLEASE PROVIDE THE FOLLOWING:

DOB: _____

Social Security Number: _____

Additional Guardian's Name: _____

Mailing Address: _____

City _____ State _____ ZIP _____

Phone: _____

GUARANTOR Name - If different from above

_____

DOB: _____

Social Security Number: _____

Guardian's Printed Name: _____

Guardian's Signature: _____

DATE signed: _____

WHITEFISH THERAPY & SPORT CENTER

I, the undersigned, acknowledge inherent risks exist when using any type of fitness equipment or engaging in physical activities. Accordingly, as consideration in exchange for being allowed to use the facility, I agree to the following:

1. I acknowledge and fully understand that I will be engaging in physical activities that involve risk of serious injury, which may include permanent disability and even death, and severe social and economic losses which might result not only from my actions, but also from the action, inaction, or negligence of others, or the condition of the premises, or any equipment used, and further that there may be risks not known to me or not reasonably foreseeable. I expressly assume all risks of injury, including death, which may occur in connection with my use of the facility.
2. I acknowledge that the facility provides for 24-hour access and will be unsupervised during much of that time. Therefore, there are additional risks such as the risk of criminal activity and that there may not be anyone at the facility to provide assistance if needed. I understand that using the facility alone is not advised.
3. I agree that prior to participating in any activity at the facility, I will inspect the facility area and all equipment to be used, and if, through my inspection, I determine that anything related to that activity is unsafe, I will immediately advise the facility of this unsafe condition and will not participate until this condition is corrected. I will also advise the facility of any unsafe or inappropriate behavior by anyone that I observe occurring at the facility.
4. I agree to assume all the foregoing risks and accept full responsibility for my own damages following any injury, permanent disability, or death. I release, waive, discharge, and agree not to sue the facility, its parent company and any subsidiaries and all its respective agents, affiliates, associates, officers, directors, owners and employees (collectively "Releases") from demands, losses, or damages on account of any bodily injury, death or property damage caused or alleged to be cause in whole or in part by Releases or any other party's actions, inactions, or otherwise. I also agree to indemnify Releases from any and all third party claims cause in whole or part by my actions.
5. I expressly agree that the terms of release and indemnity contained herein are intended to be as broad and inclusive as it is permitted by the laws of the state of Montana. Any provision or portion of this agreement found to be invalid by the courts having jurisdiction shall be invalid only with respect to such provision or portion. The offending provision or portion shall be construed to the maximum extent possible to confer upon the parties the benefits intended thereby. Said provision or portion, as well as the remaining provision or portion hereof, shall be construed and enforced to the same effect as if such offending provision or portion thereof had not been contained herein.
6. I agree to abide by all rules of the facility, and understand and agree that my membership (if applicable) may be terminated at any time at the discretion of the facility.

I have read the above and understand that by signing below
I am giving up substantial rights for myself and/or on behalf of my child or guarantee.

NAME (Printed) _____ Date _____

Signature of self/parent/guardian _____

Participant/Child's Name (Printed) Consent required if under the age of 18 _____

Mailing Address_____

Email Address _____

Date of Birth _____ Home Phone # _____ Cell Phone # _____

Emergency Contact Name_____ Phone # _____ Relationship_____